

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
01278
CERTIFICATE OF DEATH
01261

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D.# 3 (Dagsboro Road)				d. STREET ADDRESS R.D.# 3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ERNEST Middle LEE Last ADKINS				4. DATE OF DEATH Month JANUARY Day 24th Year 19 62			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 7, 1887	
9. AGE (In years lost birth day) 74 yrs.		IF UNDER 1 YEAR Months 3 Days 7		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter- House Construction				10b. KIND OF BUSINESS OR INDUSTRY Wicomico Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
11. BIRTHPLACE (State or foreign country) U S A							
13. FATHER'S NAME Peter H. Adkins				14. MOTHER'S MAIDEN NAME Mary Holland			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk				16. SOCIAL SECURITY NO. 			
17. INFORMANT Mrs. Addie M. Adkins (Wife) Address R.D.# 3 Salisbury, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hemorrhage 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of lung (Bronchiogenic) DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH 1 hour 6 mos ±	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A			
20c. TIME OF INJURY Month, Day, Year Hour o. m. N/A p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) N/A	
20f. (City or town) N/A (County) N/A (State) N/A							
21. I certify that (I) (this hospital) attended the deceased from 6/1 19 61 to death 19 62 , that (I) (we) lost saw the deceased alive on 1/20 19 62 and that death occurred at 5:30 A M, from the causes and on the date stated above.							
22a. SIGNATURE Ernest M. Larmore				22b. DATE Jan. 1/1962			
22c. PHYSICIAN'S NAME (Type) Dr. Ernest M. Larmore				22d. ADDRESS Delmar, XXXX Delaware			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 26, 1962		23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		23d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY ADDRESS SALISBURY, MARYLAND				25a. REC'D BY REGISTRAR Jan 30 '62		25b. REGISTRAR'S SIGNATURE Arthur E. Thomas	



1917

CERTIFICATE OF DEATH

1917

Blank certificate form with faint horizontal lines and vertical columns for text entry.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01279

CERTIFICATE OF DEATH

01262

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City</u> 23X-2 d. STREET ADDRESS <u>K.F.D.I. Bx. 40</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MAMIE E. AMES</u>		4. DATE OF DEATH <u>JANUARY 11, 1962</u>		5. SEX <u>FEMALE</u> 6. COLOR OR RACE <u>NEGRO</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>Dec. 24, 1891</u>		9. AGE (In years last birthday) <u>70</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>George Garrison</u>		14. MOTHER'S MAIDEN NAME <u>Lonnie Savage</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)	
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Lena Washington</u> Address <u>Pocomoke City, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO (b) <u>Chronic Glomerulonephritis</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (c) <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5 Jan</u> <u>1962</u> to <u>11 Jan</u> <u>1962</u> , that (I) (we) last saw the deceased alive on <u>11 Jan</u> <u>1962</u> , and that death occurred at <u>2</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Joseph F. General</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-14-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Red Hill Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Keller Va.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Samuel Savage</u> ADDRESS <u>New Church, Va.</u>				25a. REC'D BY REGISTRAR <u>JAN 17 '62</u> DATE		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>	

TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01219

✓ F.D.I. 1840

Dec 24, 1841 20

No George Garrison
Donat House Wk Virginia
AZU Lennie Zinade
Leno Washington (George C. Foy)

Samuel Jones New Church, Va.
1-14-42 1st Hill Com

Kellen Va

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MAYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																	
01280																	
Items 8 & 9 Film G306 1/31/62 ink																	
01263																	
1. PLACE OF DEATH a. COUNTY Wicomico				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Wicomico													
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) White Haven													
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Deer's Head State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) First Woodland Middle A. Last Anderson				4. DATE OF DEATH Month January Day 16 Year 19 62													
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/28/1878		9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant				10b. KIND OF BUSINESS OR INDUSTRY Gen. Merchandise				11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME William J. Anderson				14. MOTHER'S MAIDEN NAME Sarah L. —													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. (If yes give war or dates of service)				17. INFORMANT Mrs Elsie Anderson									
				Address White Haven, Md.													
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (b) Fracture of the right femur (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour 9 a.m. 19 p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from Jan. 3 , 19 62 , to Jan. 16 , 19 62 , that (I) (we) last saw the deceased alive on Jan. 16 , 19 62 , and that death occurred at 8:55 A.M. , from the causes and on the date stated above. 22a. SIGNATURE L. V. Maldve M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED 1/16/62 22c. PHYSICIAN'S NAME (Type) L. V. Maldve, M. D. 22d. ADDRESS Deer's Head Hospital; Salisbury, Md.										INTERVAL BETWEEN ONSET AND DEATH 4 days 2 months		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial												23b. DATE THEREOF 1/18/62		23c. NAME OF CEMETERY OR CREMATORY St Mary's Cem.		23d. LOCATION (City, town or county) (State) Tyaskin, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE C. M. Leonard						ADDRESS Drusve, Md.		25a. REC'D BY REGISTRAR DATE JAN 18 '62		25b. REGISTRAR'S SIGNATURE Arthur E. Kline							

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 12		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		d. STREET ADDRESS 711 E. Isabella St	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) D.O.A. - Pen Gen Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) STANLEY JOHN BARABAS				4. DATE OF DEATH Month JANUARY Day 12 Year 1962			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Jan. 25, 1907	9. AGE (In years last birthday) 54 yrs.	IF UNDER 1 YEAR Months 11 Days 17	IF UNDER 24 HRS. Hours 11 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee-J.I. Wells Co. (Sawman)		10b. KIND OF BUSINESS OR INDUSTRY Pa.		11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY U S A	
13. FATHER'S NAME John Barabas				14. MOTHER'S MAIDEN NAME Sophia Opusinski			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. II		17. INFORMANT Mrs. Mary Stanitski (Sister) 213 West 22nd Street Chester, Pa. (TR-4-1259)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH Sudden							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Salisbury, Maryland		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Dr. Earl L. Royer EXAMINER'S NAME (Type) 407 Camden Ave. Salisbury, Md				DATE SIGNED Jan. 15 / 1962			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Jan. 16, 1962		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or country) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR HOLLOWAY & COMPANY				24a. REC'D BY REGISTRAR JAN 18 '62			
ADDRESS SALISBURY, MARYLAND				24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hanna</i>			

2009

19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100 101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200 201 202 203 204 205 206 207 208 209 210 211 212 213 214 215 216 217 218 219 220 221 222 223 224 225 226 227 228 229 230 231 232 233 234 235 236 237 238 239 240 241 242 243 244 245 246 247 248 249 250 251 252 253 254 255 256 257 258 259 260 261 262 263 264 265 266 267 268 269 270 271 272 273 274 275 276 277 278 279 280 281 282 283 284 285 286 287 288 289 290 291 292 293 294 295 296 297 298 299 300 301 302 303 304 305 306 307 308 309 310 311 312 313 314 315 316 317 318 319 320 321 322 323 324 325 326 327 328 329 330 331 332 333 334 335 336 337 338 339 340 341 342 343 344 345 346 347 348 349 350 351 352 353 354 355 356 357 358 359 360 361 362 363 364 365 366 367 368 369 370 371 372 373 374 375 376 377 378 379 380 381 382 383 384 385 386 387 388 389 390 391 392 393 394 395 396 397 398 399 400 401 402 403 404 405 406 407 408 409 410 411 412 413 414 415 416 417 418 419 420 421 422 423 424 425 426 427 428 429 430 431 432 433 434 435 436 437 438 439 440 441 442 443 444 445 446 447 448 449 450 451 452 453 454 455 456 457 458 459 460 461 462 463 464 465 466 467 468 469 470 471 472 473 474 475 476 477 478 479 480 481 482 483 484 485 486 487 488 489 490 491 492 493 494 495 496 497 498 499 500 501 502 503 504 505 506 507 508 509 510 511 512 513 514 515 516 517 518 519 520 521 522 523 524 525 526 527 528 529 530 531 532 533 534 535 536 537 538 539 540 541 542 543 544 545 546 547 548 549 550 551 552 553 554 555 556 557 558 559 560 561 562 563 564 565 566 567 568 569 570 571 572 573 574 575 576 577 578 579 580 581 582 583 584 585 586 587 588 589 590 591 592 593 594 595 596 597 598 599 600 601 602 603 604 605 606 607 608 609 610 611 612 613 614 615 616 617 618 619 620 621 622 623 624 625 626 627 628 629 630 631 632 633 634 635 636 637 638 639 640 641 642 643 644 645 646 647 648 649 650 651 652 653 654 655 656 657 658 659 660 661 662 663 664 665 666 667 668 669 670 671 672 673 674 675 676 677 678 679 680 681 682 683 684 685 686 687 688 689 690 691 692 693 694 695 696 697 698 699 700 701 702 703 704 705 706 707 708 709 710 711 712 713 714 715 716 717 718 719 720 721 722 723 724 725 726 727 728 729 730 731 732 733 734 735 736 737 738 739 740 741 742 743 744 745 746 747 748 749 750 751 752 753 754 755 756 757 758 759 760 761 762 763 764 765 766 767 768 769 770 771 772 773 774 775 776 777 778 779 780 781 782 783 784 785 786 787 788 789 790 791 792 793 794 795 796 797 798 799 800 801 802 803 804 805 806 807 808 809 810 811 812 813 814 815 816 817 818 819 820 821 822 823 824 825 826 827 828 829 830 831 832 833 834 835 836 837 838 839 840 841 842 843 844 845 846 847 848 849 850 851 852 853 854 855 856 857 858 859 860 861 862 863 864 865 866 867 868 869 870 871 872 873 874 875 876 877 878 879 880 881 882 883 884 885 886 887 888 889 890 891 892 893 894 895 896 897 898 899 900 901 902 903 904 905 906 907 908 909 910 911 912 913 914 915 916 917 918 919 920 921 922 923 924 925 926 927 928 929 930 931 932 933 934 935 936 937 938 939 940 941 942 943 944 945 946 947 948 949 950 951 952 953 954 955 956 957 958 959 960 961 962 963 964 965 966 967 968 969 970 971 972 973 974 975 976 977 978 979 980 981 982 983 984 985 986 987 988 989 990 991 992 993 994 995 996 997 998 999 1000 1001 1002 1003 1004 1005 1006 1007 1008 1009 1010 1011 1012 1013 1014 1015 1016 1017 1018 1019 1020 1021 1022 1023 1024 1025 1026 1027 1028 1029 1030 1031 1032 1033 1034 1035 1036 1037 1038 1039 1040 1041 1042 1043 1044 1045 1046 1047 1048 1049 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01282

01265

1. PLACE OF DEATH e. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Talbot</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Michaels</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>8 Mos. 6 Days</u>		d. STREET ADDRESS <u>20x2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Deer's Head State Hospital</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Andrew</u> <u>Barnett</u>		4. DATE OF DEATH Month Day Year <u>January</u> <u>13</u> <u>19 62</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-12-05</u>
9. AGE (In years last birthday) <u>56</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Andrew Barnett</u>	
14. MOTHER'S MAIDEN NAME <u>Bertha Johnson</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>218-10-9865</u>		17. INFORMANT Address <u>Hospital Records -- Salisbury, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Recurrent Cerebral Thrombosis w/quadruplegia</u> DUE TO (b) <u>Arteriosclerosis, General</u> DUE TO (c) <u>Arteriosclerotic Cardiovascular Disease</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (e), stating the underlying cause last. <u>331X</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Arteriosclerotic Cardiovascular Disease</u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State) <u>St. Michaels Md.</u>
21. I certify that (I) (this hospital) attended the deceased from <u>5/8/61</u> , 19 , to <u>1/13/62</u> , 19 , that (I) (we) last saw the deceased alive on <u>1/13/62</u> , 19 , and that death occurred at <u>12:10 P.M.</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>V. Juerman</u>		22b. DATE SIGNED <u>1/13/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>V. Juerman, M.D.</u>		22d. ADDRESS <u>Deer's Head State Hospital - Salisbury</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1-17-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Michaels Cem.</u>	23d. LOCATION (City, town or county) (State) <u>St. Michaels Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Roswell, Easton, Md.</u>		25a. REC'D BY REGISTRAR <u>AN 16 '62</u>	25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoma</u>

11582

(M)

(1)

6-12-62

Arthur T. Brown
Bertha Johnson

11582

11-17-62

11-17-62

11-17-62

James H. Brown, Jr.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
SM 2/57

Items 18&21 Film 306
2-5-62 ams

01283

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 01266

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>X</u> <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. at Pen Gen. Hospital</u>			/d. STREET ADDRESS <u>R.D.# 3 Delmar Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>VERONICA</u> Last <u>BAYLY</u>			4. DATE OF DEATH Month <u>JANUARY</u> Day <u>23</u> Year <u>1962</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 12, 1909</u>	9. AGE (In years last birthday) <u>52</u> yrs.	IF UNDER 1 YEAR Months <u>8</u> Days <u></u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Ashley, Pa.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>		13. FATHER'S NAME <u>Bernard Kazakavage</u>			
14. MOTHER'S MAIDEN NAME <u>Frances Berryusavage</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Mr. Martin Kassey (Brother)</u> Address <u>#69 Fall St Ashley, Pa.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute alcoholism</u> <u>322.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Chronic Alcoholism</u> (a), stating the underlying cause lost. DUE TO (c) <u></u>					INTERVAL BETWEEN ONSET AND DEATH <u>hours</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u></u> o. m. <u>19</u> p. m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <u></u>	(County) <u></u>	(State) <u></u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Dr. Earl L. Royer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>January 25, 1962</u>	
EXAMINER'S NAME (Type) <u>407 Camden Ave. Salisbury, Md</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 25, 1962</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>	
22d. LOCATION (City, town, or county) <u>Salisbury, Maryland</u>		22e. (State) <u></u>		22f. (City, town, or county) <u></u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u>		ADDRESS <u>SALISBURY, MARYLAND</u>		24a. REC'D BY REGISTRAR <u>JAN 30 '62</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>					

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any, give name, address, and telephone number of the person to whom the certificate is to be forwarded. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/6D

1
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01284 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01267

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Showell d. STREET ADDRESS 23X-2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Clifford Calvin Bell		4. DATE OF DEATH Month Day Year 1-6-62 19	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 1, 1902
9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Own business	
11. BIRTHPLACE (State or foreign country) Accomac Co., Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alonzo R. Bell		14. MOTHER'S MAIDEN NAME Mag Kellam	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) -		16. SOCIAL SECURITY NO. 227-05-0904	
17. INFORMANT Elizabeth Beel		Address Showell, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushed chest. DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (c) _____ DUE TO (d) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH Sudden			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Driving car that ran off road and overturned.	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 10:30 a.m. 1-6-62	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) U.S. # 50	20f. (City or town) Willards (County) Wicomico (State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Earl L. Royer, M.D. 407 Camden Ave. Salisbury, Md.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-9-62	
22c. NAME OF CEMETERY OR CREMATORY Fairview Lawn Cem.		22d. LOCATION (City, town, or country) Onancock Va.	
23. FUNERAL DIRECTOR Henry N. Watson		24a. REC'D BY REGISTRAR JAN 12 '62	
24b. REGISTRAR'S SIGNATURE Charles L. Kline			

MEDICAL CERTIFICATION

FOR STATE
OFFICE USE



RECEIVED
FEB 18 1964
U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535

158-103-101

ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED

DATE 10-1-83 BY SP-10

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DATE 10-1-83 BY SP-10

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01285

01268

1. PLACE OF DEATH e. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY —			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 83 days			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Deer's Head State Hospital				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. STREET ADDRESS 31st and St. Paul Streets				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Sara Middle Howard Last Bier				4. DATE OF DEATH Month Jan. Day 29 Year 19 62			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 2, 1875	
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months — Days —		IF UNDER 24 HRS. Hours — Min. —			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME John William Rombach				14. MOTHER'S MAIDEN NAME Clara Faux			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. (If yes give number or dates of service) —			
17. INFORMANT Mr. John S. Rombach-Stevensville, Maryland				Address —			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-pneumonia DUE TO (b) Malignant tumor of right femoral bone (type to be determined) with metastasis DUE TO (c) — Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH 3 days 6 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) —			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) (County) (State) —	
21. I certify that (I) (this hospital) attended the deceased from Nov. 7, 1961 , to Jan. 29, 1962 , that (I) (we) last saw the deceased alive on Jan. 29, 1962 , and that death occurred at 3:15 P.M. from the causes and on the date stated above.							
22a. SIGNATURE L. V. Maldve, M. D.				22b. DATE SIGNED 1/30/62		22c. PHYSICIAN'S NAME (Type) L. V. Maldve, M. D.	
22d. ADDRESS Deer's Head Hospital; Salisbury, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-1-62		23c. NAME OF CEMETERY OR CREMATORY Watsonstown Cemetery		23d. LOCATION (City, town or county) (State) Watsonstown, Pa.	
24. FUNERAL DIRECTOR'S SIGNATURE Wm J. Johnson, Baltimore 19, Md.				25a. REC'D BY REGISTRAR Jan 31 '62		25b. REGISTRAR'S SIGNATURE —	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

29510

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01286 Items 5 & 6 Film G305 1/25/62 ink 01286											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Wicomico					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 12 Salisbury					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1009 N. Divison St.						d. STREET ADDRESS 1009 N. Divison St.					
3. NAME OF DECEASED (Type or print) Mary C. Birkhead						4. DATE OF DEATH January 15 1962					
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>		8. DATE OF BIRTH October 20, 1863		9. AGE (In years last birthday) 98 yrs.		IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife						10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Elisha Dixon						14. MOTHER'S MAIDEN NAME Ann Parker					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No						16. SOCIAL SECURITY NO. John Birkhead/1009 N. Divison St					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 450 DUE TO gangrene right leg Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from 1-14-1962 to 1-15-1962 , that (I) (we) last saw the deceased alive on 1-14-1962 , and that death occurred at M , from the causes and on the date stated above.											
22a. SIGNATURE Frederic J. [Signature] M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type)						22b. DATE SIGNED JAN 22 '62					
23a. BURIAL, CREMATION, REMOVAL (Specify) burial						23b. DATE THEREOF 1/19/1962		23c. NAME OF CEMETERY OR CREMATORY Green acres		23d. LOCATION (City, town or county) (State) Salisbury Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Christopher F. Stewart						25a. REC'D BY REGISTRAR JAN 22 '62		25b. REGISTRAR'S SIGNATURE Arthur S. [Signature]			

03222



also

also

1002 A. Division

1002 A. Division

also

also

October 20, 1902

also

also

also

also

Handwritten notes in the center of the page, possibly a signature or set of initials.

partial 1/19/1902

partial 1/19/1902

partial 1/19/1902

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01287

CERTIFICATE OF DEATH

01270

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY in 1b <u>1 Week</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsular General Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u> d. STREET ADDRESS <u>RFD #1 Box 147</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Cordelia</u> Middle <u>Blake</u> Last			4. DATE OF DEATH Month <u>January</u> Day <u>22</u> Year <u>1962</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>May 29 - 1904</u>		9. AGE (In years last birthday) <u>57 7/8</u>		IF UNDER 1 YEAR Months <u>7</u> Days <u>22</u> Hours <u>17</u> Min. <u>30</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Haywife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Broxhome</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>Snow Hill, Md</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Calvin Laws</u>		14. MOTHER'S MAIDEN NAME <u>Mary Sturgis</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>M. Whitcomb Blake, Snow Hill, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO (b) <u>Metastatic Carcinoma of breast</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital), attended the deceased from <u>1/16</u> , 19 <u>62</u> , to <u>1/22</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>1/22</u> , 19 <u>62</u> , and that death occurred at <u>7:45</u> P.M., from the causes and on the date stated above.							
22a. SIGNATURE <u>David Rafat MD</u>				22b. DATE SIGNED <u>1/22</u>			
22c. PHYSICIAN'S NAME (Type) <u>DAVID RAFAT MD</u>				22d. ADDRESS <u>Snow Hill Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Funeral Jan 27/62</u>		23b. DATE THEREOF <u>Jan 27/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>West Wesley</u>			
23d. LOCATION (City, town or county) <u>Snow Hill</u>		(State) <u>Md</u>		25a. REC'D BY REGISTRAR <u>JAN 24 '62</u>			
24. POWER OF ATTORNEY SIGNATURE <u>Way & Dennis</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Trans</u>		25c. DATE <u>JAN 24 '62</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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(M)

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01288

01271

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>Life</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mardella Springs Rural</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Marada Elizabeth Brown</u> First Middle Last				4. DATE OF DEATH <u>January 13 1962</u> Month Day Year			
5. SEX <u>FEMALE</u> 6. COLOR OR RACE <u>NEGRO</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1893</u> yrs.		9. AGE (In years last birthday) <u>68</u> IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Domestic</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Shoptown</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Geo Hopkins</u>				14. MOTHER'S MARRIED NAME <u>Ardella Ennis</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>?</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>?</u> 17. INFORMANT <u>Broce Gaslee</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Wile gastric hemorrhage</u> 151X DUE TO <u>Carcinoma of stomach</u> Conditions, if any, which gave rise to immediate cause (b) <u>months</u> (a), stating the underlying cause last. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1-11-62</u> to <u>1-13-62</u> , that (I) (we) last saw the deceased alive on <u>1-13-62</u> , and that death occurred at <u>12:30 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>H. H. Brielle</u> M.D.				22b. DATE SIGNED <u>1-13-62</u> 22c. PHYSICIAN'S NAME (Type) <u>H. H. Brielle</u> 22d. ADDRESS <u>Medical Center Salisbury Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-17-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Shoptown Cem</u>		23d. LOCATION (City, town or county) <u>Shoptown Md</u> (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Brooke M. M. M.</u> ADDRESS				25a. REC'D BY REGISTRAR <u>JAN 17 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01228

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01289

01272

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b 3 Years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springhill Sanitarium				2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) e. STATE Delaware b. COUNTY Suxxex c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Selbyville d. STREET ADDRESS RFD e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
3. NAME OF DECEASED (Type or print) Cora M. BUNTING		4. DATE OF DEATH Month Day Year Jan. 6 19 62		5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-3-1874		9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home				11. BIRTHPLACE (County & State, or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME William Collins						14. MOTHER'S MAIDEN NAME Kathryn Hudson											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) XX XX XXXX				16. SOCIAL SECURITY NO. XXXX				17. INFORMANT Address Raymond Bunting Selbyville, Del.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Cerebral Thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH 1 yr.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)					
21. I certify that (I) (this hospital) attended the deceased from 1/6/62 , 19 62 , to 1-6-62 , 19 62 ; that (I) (we) last saw the deceased alive on 1/6/62 , 19 62 , and that death occurred at 1:35 P.M. causes and on the date stated above.																	
22a. SIGNATURE E. M. Beardsley						22b. DATE SIGNED 1/6/62		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS 207 Maryland Ave., Salisbury, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial						23b. DATE THEREOF 1/9/62		23c. NAME OF CEMETERY OR CREMATORY Odd Fellows		23d. LOCATION (City, town or county) (State) Bishopville, Md.							
24. FUNERAL DIRECTOR'S SIGNATURE Edgar Whaley Selbyville, Del.						25a. REC'D BY REGISTRAR JAN 17 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Francis									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

(1)

Bonting

1-3-02

1:32 P.M.

Handwritten signature

S. W. Beardsley, Jr.

307 Maryland Ave., Baltimore, Md.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
01290 CERTIFICATE OF DEATH 01273

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 12			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen Gen Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LEMUEL Middle MALONE Last CANNON				4. DATE OF DEATH Month JANUARY Day 16 Year 19 62			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 11, 1871	
9. AGE (In years lost birthday) 90		10. IF UNDER 1 YEAR Months 4 Days 5		11. IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired "Rigger"				10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Wicomico Co. Maryland	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME William Cannon				14. MOTHER'S MAIDEN NAME Mary E. Gaskill			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 		17. INFORMANT Mrs. Edward C. Adkins (Daughter) Address 2405 Farley Place S.E. - Washington 21, D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Biliary Cirrhosis - DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ADENOCARCINOMA - COMMON BILE DUCT DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 3 mos.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 	
20f. (City or town) 				20g. (County) 			
20h. (State) 							
21. I certify that (I) (this hospital) attended the deceased from 2:45 P.M. 19 62 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at 2:45 P.M. 19 62 , from the causes and on the date stated above.							
22a. SIGNATURE H. Gray Reeves M.D.				22b. DATE SIGNED Jan. 18 /1962			
22c. PHYSICIAN'S NAME (Type) Dr. Gray Reeves				22d. ADDRESS Medical Center Salisbury, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Jan. 19, 1962		23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery	
23d. LOCATION (City, town, or county) Salisbury, Maryland							
24. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY				ADDRESS SALISBURY, MARYLAND		25a. REC'D BY REGISTRAR JAN 22 '62	
25b. REGISTRAR'S SIGNATURE Arthur L. Kline							

01500

CERTIFICATE OF DEATH

WEST VIRGINIA DEPARTMENT OF HEALTH
DIVISION OF PUBLIC HEALTH AND PREVENTION
OFFICE OF THE STATE HEALTH COMMISSIONER



Given C/181012

ADMONITION - COMMON BILE BUCT 3-12

11 years 10 months

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01291

CERTIFICATE OF DEATH

Items 7 & 9 Film G505 1/22/62 iwk

01274

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Maryland b. COUNTY Caroline		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Preston		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital			d. STREET ADDRESS Rt. # 2		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Winfield Middle Dewey Last Chambers			4. DATE OF DEATH Month January Day 16 Year 19 62		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 17, 1898	9. AGE (In years last birthday) 63 6/4	IF UNDER 1 YEAR Months 6 Days 4
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bascomb Chambers Lumber			11. BIRTHPLACE (County & State, or foreign country) Caroline Md.		
13. FATHER'S NAME Bascomb Chambers			14. MOTHER'S MAIDEN NAME Ida Todd		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give year or dates of service)			16. SOCIAL SECURITY NO. 213-16-8296		
17. INFORMANT Mrs. Audrey Lee Webster			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of left lung DUE TO (b) 163X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) 163X					INTERVAL BETWEEN ONSET AND DEATH 1 1/2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Nephrosclerosis, arteriolar					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from August 31, 1961 to January 16, 1962 , that (I) (we) last saw the deceased alive on Jan. 15, 1962 , and that death occurred at 4:55 A.M. from the causes and on the date stated above.					
22a. SIGNATURE V. Juerman			22b. DATE SIGNED 1/16/62		
22c. PHYSICIAN'S NAME (Type) V. Juerman, M. D.			22d. ADDRESS Deer's Head Hospital; Salisbury, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Jan. 19		
23c. NAME OF CEMETERY OR CREMATORY Jr. O. U. A. M.			23d. LOCATION (City, town or county) (State) Preston, Md.		
24. FUNERAL DIRECTOR'S SIGNATURE Harry M. Hollis			25a. REC'D BY REGISTRAR DATE JAN 19 '62		
25b. REGISTRAR'S SIGNATURE Arthur S. Kneel					

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01292

01275

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>365 days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Deer's Head State Hospital</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 Salisbury</u>			
d. STREET ADDRESS <u>623 Lake Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Roy James Corbin</u>				4. DATE OF DEATH Month <u>January</u> Day <u>10</u> Year <u>19 62</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1886</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Editor</u>	
11. BIRTH PLACE (County & State, or foreign country) <u>Worcester Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>George Corbin</u>		14. MOTHER'S MAIDEN NAME <u>Mary Collins</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Colored Corbin</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RECURRENT CEREBRAL THROMBOSIS</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerosis general</u> (c) <u> </u> DUE TO (e), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 10</u> , 19 <u>61</u> to <u>Jan. 10</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>Jan. 10</u> , 19 <u>62</u> , and that death occurred at <u>9:30 A.M.</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>V. Juerman</u>				22b. DATE SIGNED <u>1/10/62</u>			
22c. PHYSICIAN'S NAME (Type) <u>V. Juerman, M. D.</u>				22d. ADDRESS <u>Deer's Head State Hospital; Salisbury, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-15-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Green Acres Cem</u>		23d. LOCATION (City, town or county) (State) <u>Salisbury Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Booker M. West</u>				25. REC'D BY REGISTRAR <u>17 '62</u>			
ADDRESS <u>130 Second St City</u>				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

01292

(1)

George Corbin
John D. Corbin
John D. Corbin
John D. Corbin

SECURITY CERTIFICATE

1941

George Corbin
John D. Corbin

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01293

CERTIFICATE OF DEATH

01276

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY in 1b <u>2 wks.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>X Salisbury R #2</u> d. STREET ADDRESS <u>1 PEMBERTON DRIVE</u>	
3. NAME OF DECEASED (Type or print) <u>MAUDE ABBOTT CUIVER</u>		4. DATE OF DEATH <u>JANUARY 28 1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/20/1881</u>
9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MERRILL ABBOTT</u>		14. MOTHER'S MAIDEN NAME <u>LILLY HUGHES</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>L. GORDY COLVER, SAME</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> (b) <u>Coronary Thrombosis</u> (c) <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive Cardiovascular Disease</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (<u>this hospital</u>) attended the deceased from <u>Jan 28, 1962</u> to <u>Jan 28, 1962</u> that (I) (we) last saw the deceased alive on <u>Jan 28, 1962</u> , and that death occurred at <u>11 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Thomas C. Hill Jr.</u> M.D.		22b. DATE SIGNED <u>1/28/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Thomas C. Hill Jr.</u>		22d. ADDRESS <u>PINE BLUFF RD, Salisbury, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>1/31/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>PARSONS CEMETERY</u>	23d. LOCATION (City, town or county) (State) <u>SALISBURY, MD.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>HILL & JOHNSON Co. Salisbury Md.</u>		25a. REC'D BY REGISTRAR <u>JAN 31 '62</u>	25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
01294 Item #8 - Film G305 - 1/24/62-mm6									
01277									
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)				
a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>					e. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Quantico</u>				
c. LENGTH OF STAY IN 1b <u>D.O.A.</u>					d. STREET ADDRESS <u>1</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>					e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Charles T. Dashiell</u>					4. DATE OF DEATH <u>JANUARY 17 1962</u>				
5. SEX <u>Male</u>					6. COLOR OR RACE <u>White</u>				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <u>8/9/1875</u>				
9. AGE (In years last birthday) <u>86</u>					10. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>				
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>					12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				
13. FATHER'S NAME <u>Charles R. Dashiell</u>					14. MOTHER'S MAIDEN NAME <u>Sally Jane Darby</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>					16. SOCIAL SECURITY NO. <u>215-20-0243</u>				
17. INFORMANT <u>Charles T. Dashiell, Quantico Md.</u>					Address <u>Quantico Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>									
331X DUE TO (b) <u>Cerebral Arteriosclerosis</u>									
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. } DUE TO (c) _____									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year <u>19</u>									
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <u>JUNE 1958</u> to <u>JAN 17, 1961</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>6:15</u> p.m. from the causes and on the date stated above.									
22a. SIGNATURE <u>Thomas C. Hill Jr. M.D.</u>									
22b. DATE SIGNED <u>1/17/62</u>									
22c. PHYSICIAN'S NAME (Type) <u>Thomas C. Hill Jr.</u>									
22d. ADDRESS <u>Pine Bluff Road, Salisbury, Md.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>									
23b. DATE THEREOF <u>1/20/62</u>									
23c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Mem. Park</u>									
23d. LOCATION (City, town or county) (State) <u>Salisbury Md.</u>									
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Bivale, Md.</u>									
25a. REC'D BY REGISTRAR <u>JAN 22 '62</u>									
25b. REGISTRAR'S SIGNATURE <u>Robert L. Hanes</u>									

01264



MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01295

01278

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
c. LENGTH OF STAY IN 1b Months				d. STREET ADDRESS 414 Pinehurst Ave			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Hill Private Sanitarium				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EDWARD Middle BREARWOOD Last DASHIELL				4. DATE OF DEATH Month January Day 31 Year 1962			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/13/1898	
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months 63 Days 0 Hours 0 Min.		11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant				10b. KIND OF BUSINESS OR INDUSTRY Electrical Utility			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Andrew J. Dashiell				14. MOTHER'S MAIDEN NAME Laura Newton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 214-10-7958		17. INFORMANT Mrs. Edward Dashiell, Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Myocardial infarct, acute DUE TO (b) 5 minutes Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) 5 minutes				INTERVAL BETWEEN ONSET AND DEATH 5 minutes			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 8:00		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6 1961 to 1-31 1962 that (I) (we) last saw the deceased alive on 1-31 1962 and that death occurred at 8:00 PM , from the causes and on the date stated above.							
22a. SIGNATURE William B. Ellis Jr.				22b. DATE 2-2-62			
22c. PHYSICIAN'S NAME (Type) WILBUR B. ELLIS Jr.				22d. ADDRESS Medical Center, Salisbury MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-3-1962		23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		23d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co. Salisbury, Maryland				25a. REC'D BY REGISTRAR FEB 6 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

01993

CERTIFICATE OF DATA

MANUAL AND MECHANICAL DATA
OFFICE OF THE SECRETARY OF DEFENSE

1. TITLE: [Illegible]
2. AUTHOR: [Illegible]
3. PERIODICITY: [Illegible]
4. DATE: [Illegible]
5. NUMBER: [Illegible]
6. VOLUME: [Illegible]
7. PART: [Illegible]
8. PAGE: [Illegible]
9. TOTAL PAGES: [Illegible]
10. ABSTRACT: [Illegible]
11. SUMMARY: [Illegible]
12. INTRODUCTION: [Illegible]
13. CONCLUSIONS: [Illegible]
14. REFERENCES: [Illegible]
15. NOTES: [Illegible]
16. COMMENTS: [Illegible]
17. DISTRIBUTION STATEMENT: [Illegible]
18. SECURITY CLASSIFICATION: [Illegible]
19. UNCLASSIFIED: [Illegible]
20. CONFIDENTIAL: [Illegible]
21. SECRET: [Illegible]
22. EXTENDED ABSTRACT: [Illegible]
23. FULL TEXT: [Illegible]
24. MICROFILM: [Illegible]
25. MICROFICHE: [Illegible]
26. OTHER: [Illegible]
27. DATE OF REVIEW: [Illegible]
28. REVIEWER: [Illegible]
29. APPROVAL: [Illegible]
30. SIGNATURE: [Illegible]
31. TITLE: [Illegible]
32. AUTHOR: [Illegible]
33. PERIODICITY: [Illegible]
34. DATE: [Illegible]
35. NUMBER: [Illegible]
36. VOLUME: [Illegible]
37. PART: [Illegible]
38. PAGE: [Illegible]
39. TOTAL PAGES: [Illegible]
40. ABSTRACT: [Illegible]
41. SUMMARY: [Illegible]
42. INTRODUCTION: [Illegible]
43. CONCLUSIONS: [Illegible]
44. REFERENCES: [Illegible]
45. NOTES: [Illegible]
46. COMMENTS: [Illegible]
47. DISTRIBUTION STATEMENT: [Illegible]
48. SECURITY CLASSIFICATION: [Illegible]
49. UNCLASSIFIED: [Illegible]
50. CONFIDENTIAL: [Illegible]
51. SECRET: [Illegible]
52. EXTENDED ABSTRACT: [Illegible]
53. FULL TEXT: [Illegible]
54. MICROFILM: [Illegible]
55. MICROFICHE: [Illegible]
56. OTHER: [Illegible]
57. DATE OF REVIEW: [Illegible]
58. REVIEWER: [Illegible]
59. APPROVAL: [Illegible]
60. SIGNATURE: [Illegible]

MADE IN U.S.A.

RECEIVED
JAN 19 1964
OFFICE OF THE SECRETARY OF DEFENSE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
01296														
01279														
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA General Hospital</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Champ</u> d. STREET ADDRESS <u>19X-2</u>									
3. NAME OF DECEASED (Type or print) <u>Nellie W. DASHIELL</u>					4. DATE OF DEATH Month <u>JANUARY</u> Day <u>20</u> Year <u>1962</u>									
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 5, 1896</u>		9. AGE (in years last birthday) <u>65</u> yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Store Keeping</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Salisbury, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
13. FATHER'S NAME <u>Byard Thomas West</u>					14. MOTHER'S MAIDEN NAME <u>Hester Phippin</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)					16. SOCIAL SECURITY NO. <u></u>					17. INFORMANT <u>Harry T. West, Champ, Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Liver Cirrhosis</u> 581.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>with Ascites</u> DUE TO (c) <u>Contrib. Diabetes Mellitus</u>										INTERVAL BETWEEN ONSET AND DEATH <u>4 mo</u> <u>3 mo</u> <u>1 yr</u>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour <u></u> a.m. <u>19</u> p.m. <u></u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1/15, 1962</u> to <u>1/20, 1962</u> that (I) (we) last saw the deceased alive on <u>JAN. 20, 1962</u> , and that death occurred at <u>10:30 AM</u> from the causes and on the date stated above.														
22a. SIGNATURE <u>W B Smith</u> M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22b. DATE SIGNED <u>1/20/62</u>				
22c. PHYSICIAN'S NAME (Type) <u>Wm. B. Smith</u>					22d. ADDRESS <u>Salisbury, Md.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>1/23, 62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Oriole Cemetery</u>			23d. LOCATION (City, town or county) <u>Oriole, Md.</u>			(State)			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leven R. Wilson</u>					ADDRESS <u></u>					25a. REC'D BY REGISTRAR <u></u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>		
DATE <u>JAN 25 '62</u>														

VR A15 (4)
15M 9/60



1892

W. S. Hester

✓

① Byrd Thomas West Hester Philip
Merchant Store keeping Salisbury, Md. U.S.A.
June 2, 1892

Wm. B. Smith
Salisbury, Md.
Burial: 123, 62 Oriole Cemetery, Md.
James B. Hester

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01297

CERTIFICATE OF DEATH

01298

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Willards</u>		c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Willards</u>		d. STREET ADDRESS <u>XX</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>XX</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>George Edward Davis</u>				4. DATE OF DEATH <u>Jan. 27, 1962</u> 19			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 18, 1882</u> 79 yrs.	
9. AGE (In years last birthday) Months Days Hours Min.		10. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				13. FATHER'S NAME <u>George E. Davis</u>			
14. MOTHER'S MAIDEN NAME <u>Millie Dishroon</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>XX</u>			
16. SOCIAL SECURITY NO. <u>217-36-1562</u>				17. INFORMANT <u>Gladys Combs Willards, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) } DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>9</u> m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> NOT While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 26, 1962</u> to <u>Jan 27, 1962</u> , that (I) (we) last saw the deceased alive on <u>Jan 27, 1962</u> , and that death occurred at <u>9 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Frank Lewis</u>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>Willards Maryland</u>				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/30/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Hope</u>		23d. LOCATION (City, town or county) (State) <u>Willards, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Peter Whaley Selbyville, Del.</u>				25a. REC'D BY REGISTRAR DATE <u>FEB 1 '62</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



01293

John White, Esq.
1000 15th St. N.W.
Washington, D.C.

1000 15th St. N.W.
Washington, D.C.

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01298

01281

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>402 Patterson Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ELLEN ELIZABETH Disharoon</u>				4. DATE OF DEATH <u>JANUARY 25 1962</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 16, 1910</u>	
9. AGE (In years last birthday) <u>51 yrs.</u>		IF UNDER 1 YEAR Months <u>4</u> Days <u>9</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work at Home</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Salisbury, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>							
13. FATHER'S NAME <u>John Parker Short</u>				14. MOTHER'S MAIDEN NAME <u>Harriett Shaw</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u></u>			
17. INFORMANT <u>Mrs. Charlotte E. Morris (Daughter)</u> <u>R.D.# 1 Parsonsburg, Maryland</u>				17. ADDRESS <u></u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u></u> (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u>7 hrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>diabetes mellitus</u>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>N/A</u>			
20c. TIME OF INJURY Hour <u></u> a.m. <u></u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>15762</u>		20f. (City or town) <u>Salisbury</u> (County) <u>Wicomico</u> (State) <u>MD</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>1/24/62</u> to <u>1/25/62</u> , that (I) (we) last saw the deceased alive on <u>1/24/62</u> , and that death occurred at <u>10 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Earl M. Beardsley</u>				M.D. <u></u>		22b. DATE SIGNED <u>Jan. 26 / 1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Earl M. Beardsley</u>				22d. ADDRESS <u>Maryland Ave. Salisbury, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan. 27, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>		23d. LOCATION (City, town or county) <u>Salisbury, Maryland</u> (State) <u>MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u>				ADDRESS <u>SALISBURY, MARYLAND</u>		25a. REC'D BY REGISTRAR <u>JAN 30 '62</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur E. Thomas</u>			

(M)

01298

General Manager

Ellen Elizabeth

James White

General Manager

Ellen Elizabeth

General Manager

McLAWAY & COMPANY, SALT LAKE CITY, UTAH

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01299

CERTIFICATE OF DEATH

1282

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> d. STREET ADDRESS <u>109 Jenkins Lane</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>EMMA</u>		4. DATE OF DEATH Last First Middle <u>Ellison</u>		Date <u>January 17</u> 19 <u>62</u> Month Day Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>April 10, 1911</u>		9. AGE (In years last birthday) <u>50</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house wife</u>			
10b. KIND OF BUSINESS OR INDUSTRY <u>Florida</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Florida</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Wheel Austin</u>			14. MOTHER'S MAIDEN NAME <u>Hattie Austin</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Charles Harmon 109 Morris Lane</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute bronchitis</u> DUE TO (b) <u>500X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>myocardial infarction - H. influenza meningitis</u> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21. I certify that (I) (this hospital) attended the deceased from <u>12/24/61</u> to <u>1/17/62</u> that (I) (we) last saw the deceased alive on <u>1/17/62</u> and that death occurred at <u>2:22 PM</u> from the causes and on the date stated above. 22a. SIGNATURE <u>Carl M. Brundley</u> M.D. 22b. PHYSICIAN'S NAME (Type) <u>Carl M. Brundley</u> 22c. ADDRESS <u>Salisbury Md.</u> 22d. ADDRESS <u>Salisbury Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>22/ 62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Green Acres</u>			
23d. LOCATION (City, town or county) (State) <u>Salisbury Md.</u>		25a. REC'D BY REGISTRAR <u>JAN 22 '62</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur E. Stewart</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur E. Stewart</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
 15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01300

CERTIFICATE OF DEATH

Item 4, Film G-306 1/30/62.cac.

01283

1. PLACE OF DEATH a. COUNTY: <u>Wicomico</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): <u>SALISBURY</u> c. LENGTH OF STAY IN 1b: _____ d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): <u>PENINSULA GENERAL Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE: <u>MARYLAND</u> b. COUNTY: <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): <u>MARDELA SPRINGS X</u> d. STREET ADDRESS: <u>MTAINIST</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>William R. English</u>		4. DATE OF DEATH Month <u>JANUARY</u> Day <u>19</u> Year <u>1962</u>		5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APRIL 12 1890</u>		9. AGE (In years last birthday) <u>71</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>FRAMER</u>				10b. KIND OF BUSINESS OR INDUSTRY : <u>-</u>				11. BIRTHPLACE (County & State, or foreign country): <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>WESLEY T. ENGLISH</u>						14. MOTHER'S MAIDEN NAME <u>DORA RUSSELL</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>216-05-982</u>				17. INFORMANT <u>Mrs Mary English - MARDELA MD</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct, acute</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>420</u> DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Arterio sclerosis obliterans</u>												INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) _____													
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. _____ p.m. _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____					
21. I certify that (I) (this hospital) attended the deceased from <u>1-9-62</u> to <u>1-19-62</u>, that (I) (we) last saw the deceased alive on <u>1-19-62</u>, and that death occurred at <u>6:50 P.M.</u> from the causes and on the date stated above.													
22a. SIGNATURE <u>William R. English</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>1-19-62</u>				
22c. PHYSICIAN'S NAME (Type) _____						22d. ADDRESS _____							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>1-23-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Riverston Church</u>		23d. LOCATION (City, town or county) <u>Riverston MD</u> (State) _____					
24. FUNERAL DIRECTOR'S SIGNATURE <u>SMITH FUNERAL HOME, SHARPTOWN, MD</u>													
25a. REC'D BY REGISTRAR DATE <u>JAN 25 '62</u>						25b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01200

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 should be detached for use as the burial-transit permit. In any event, within 72 hours after death, be filed with the State Dept. of Health prior to burial, cremation, or removal.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01301											
01284											
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> d. STREET ADDRESS <u>733 S.Division St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>BETTY NMI ENNIS</u>						4. DATE OF DEATH <u>JANUARY 22 1962</u> Month Day Year					
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Baby <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JANUARY 22 1962</u>		9. AGE (In years last birthday) <u>0</u> yrs. <u>0</u> Months <u>0</u> Days <u>7</u> Min. <u>38</u>		IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Wicomico MARYLAND</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>WILLIAM JAMES ENNIS</u>						14. MOTHER'S MAIDEN NAME <u>PATRICIA ANN Nibblett</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes give war or dates of service)</u>				16. SOCIAL SECURITY NO. <u>INFORMANT</u>		17. ADDRESS <u>Mr. Wm. J. Ennis (Father) 733 S.Division St Salisbury, Maryland</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple congenital anomalies, including</u> DUE TO <u>Hydrocephalus, meningococci - complete</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>spina bifida</u> DUE TO <u>spina bifida</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>N/A</u>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1945</u> to <u>1962</u> , that (I) (we) last saw the deceased alive on <u>12/28/61</u> and that death occurred at <u>12/28/62</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Robert Lee Baker</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Jan. 22, 1962</u>			
22c. PHYSICIAN'S NAME (Type) <u>Dr. Robert Lee Baker</u>						22d. ADDRESS <u>Medical Center Salisbury, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Jan. 23, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Salisbury, Maryland</u>			
24 FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u> ADDRESS <u>SALISBURY, MARYLAND</u>						25a. REC'D BY REGISTRAR <u>JAN 26 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Huns</u>			

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01302

CERTIFICATE OF DEATH

01285

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Wicomico</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>1 hr.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury 12</u>									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>602 Liberty 1</u>									
3. NAME OF DECEASED (Type or print) First Middle Last <u>Levi Edward EURE</u>				4. DATE OF DEATH Month Day Year <u>JANUARY 24 1962</u>									
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>									
8. DATE OF BIRTH <u>9/21/1907</u>		9. AGE (In years last birthday) <u>54</u> yrs. <table border="1" style="display: inline-table; vertical-align: top;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months Days</td> <td>Hours Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months Days	Hours Min.						
IF UNDER 1 YEAR	IF UNDER 24 HRS.												
Months Days	Hours Min.												
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lumberman Timber Cutter</u>				11. BIRTHPLACE (County & State, or foreign country) <u>N.C.</u>									
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>													
13. FATHER'S NAME <u>J. Zundy Eure</u>				14. MOTHER'S MAIDEN NAME <u>—</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes World War II</u>				16. SOCIAL SECURITY NO. <u>—</u>									
17. INFORMANT Address <u>Marie Heath Eure, 602 Liberty St, Salisbury, Md.</u>													
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <table border="1" style="width: 100%;"> <tr> <td colspan="2"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. </td> <td> (b) . </td> <td> (c) . </td> </tr> <tr> <td colspan="4"> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) </td> </tr> </table>						PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.		(b) .	(c) .	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.		(b) .	(c) .										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)													
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. . 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town)		(County)		(State)									
21. I certify that (I) (this hospital) attended the deceased from <u>1-24</u> , 19 <u>62</u> , to <u>1-24</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>1-24</u> , 19 <u>62</u> , and that death occurred at <u>3:20 PM</u> , from the causes and on the date stated above.													
22a. SIGNATURE <u>Philip A. Insley</u> M.D.				22b. DATE SIGNED ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>Salisbury, Md.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>													
23b. DATE THEREOF <u>1/27/62</u>													
23c. NAME OF CEMETERY OR CREMATORY <u>Wic. Mem. Park Cem.</u>													
23d. LOCATION (City, town or county) <u>Salisbury, Md.</u>													
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. Messing, Div 3160, Md.</u> ADDRESS													
25a. REC'D BY REGISTRAR <u>FEB 1 '62</u>													
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>													

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The certificate may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2062

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01303

01286

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Queen Anne			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 4 Yrs. 5 Mos. 15 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millington		d. STREET ADDRESS 17X-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Anna Middle --- Last Everett				4. DATE OF DEATH Month January Day 8 Year 19 62			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 27, 1872	9. AGE (In years last birthday) 89 yrs.	IF UNDER 1 YEAR Months --- Days ---	IF UNDER 24 HRS. Hours --- Min. ---	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unk.		10b. KIND OF BUSINESS OR INDUSTRY Unk.		11. BIRTHPLACE (County & State, or foreign country) Caroline County		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas Emory				14. MOTHER'S MAIDEN NAME CHARITY Clough			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) NONE.		16. SOCIAL SECURITY NO. NONE.		17. INFORMANT Hospital Records --- Salisbury, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 450.0 DUE TO Death Myocardial Failure Conditions, if any, which gave rise to immediate cause (b) Generalized Arteriosclerosis (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 2 days 10 yrs.						INTERVAL BETWEEN ONSET AND DEATH 2 days 10 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. ---	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from 7/21/57 , 19 --- , to 1/8/62 , 19 --- , that (I) (we) last saw the deceased alive on 1/8/62 , 19 --- , and that death occurred at 8:--- M, from the causes and on the date stated above.							
22a. SIGNATURE Lee L. Lawry		M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 1/8/62	
22c. PHYSICIAN'S NAME (Type) Lee L. Lawry, M.D.		22d. ADDRESS Deer's Head Hospital - Salisbury, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF Jan. 11, 62	23c. NAME OF CEMETERY OR CREMATORY MASSEY CEM.		23d. LOCATION (City, town or county) (State) MASSEY RENT Co., Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Edward Fellows			ADDRESS Millington, Md.		25a. REC'D BY REGISTRAR ---		
25b. REGISTRAR'S SIGNATURE ---			DATE JAN 11 '62				

(M)

01203

Charity

None.

Exhibit for W. C. Massey, Gen. Massey, Kentucky
Exhibit for W. C. Massey, Gen. Massey, Kentucky

may be reviewed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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01304
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
01287

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b X			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen Gen Hospital				e. STREET ADDRESS R.D.# 2 Spring Hill Road			
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First SADIE Middle ELLEN Last FLEMING				4. DATE OF DEATH Month JANUARY Day 29 Year 1962			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED X DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 24, 1890	
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR 10 Months 5 Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work at Home				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Tarrall Co. N. Carolina	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Mathis Levy Tarkengton				14. MOTHER'S MAIDEN NAME Frances Elizabeth Brickhouse			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)			
17. INFORMANT Mr. H. J. Forbes (Son)				Address R.D.# 2 Spring Hill Rd Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 332X DUE TO (c) essential hypertension PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) essential hypertension INTERVAL BETWEEN ONSET AND DEATH 48 hours							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A							
20c. TIME OF INJURY Month, Day, Year Hour o. m. N/A 19 p. m. N/A				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) N/A				20f. (City or town) N/A (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 10/5 19 62 , that (I) (we) last saw the deceased alive on 1/29 19 62 , and that death occurred at 3:35 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Earl M. Beadsley M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED Jan. 30 / 1962							
22c. PHYSICIAN'S NAME (Type) Dr. Earl M. Beadsley 22d. ADDRESS Md Ave. Salisbury, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Feb. 1, 1962			
23c. NAME OF CEMETERY OR CREMATORY Spring Hill Memory Gardens				23d. LOCATION (City, town, or county) (State) Salisbury, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY				25a. REC'D BY REGISTRAR FEB 1 '62 25b. REGISTRAR'S SIGNATURE Arthur E. Harts			

CERTIFICATE OF DEATH

01302

(M)

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UNITED STATES

DEPARTMENT OF HEALTH

AND HUMAN SERVICES

1968

1968

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01305 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01288

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
c. LENGTH OF STAY IN 1b 1		d. STREET ADDRESS Mineola Ave. Route # 2	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Mineola Ave. Route # 2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William R Fletcher		4. DATE OF DEATH 1-8-62	
5. SEX M	6. COLOR OR RACE AA	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-22-04
9. AGE (In years last birthday) 57 yrs.		10. IF UNDER 1 YEAR Months 1 Days 8	
11. IF UNDER 24 HRS. Hours 19 Min.		12. CITIZEN OF WHAT COUNTRY? U S A	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY Restaurant	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME West Gunby		14. MOTHER'S MAIDEN NAME Emma Fletcher	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. Mrs. Margaret Fletcher, Salisbury, Md	
17. INFORMANT Mrs. Margaret Fletcher, Salisbury, Md		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malnutrition DUE TO (b) Carcinoma of the esophagus DUE TO (c) 150X Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.			
INTERVAL BETWEEN ONSET AND DEATH Months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) 407 Camden Avenue Salisbury, Md		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-12-62	
22c. NAME OF CEMETERY OR CREMATORY Green Acres Cemetery		22d. LOCATION (City, town, or country) (State) Salisbury Wicomico Md.	
23. FUNERAL DIRECTOR Thornton B. Jolley, Salisbury, Md.		24a. REC'D BY REGISTRAR JAN 15 '62	
24b. REGISTRAR'S SIGNATURE Arthur S. K...		DATE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please see the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR SALE
REAR VIEW



John J. Jones

John J. Jones, Secretary, etc.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01306

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>Sussex</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MILLSBORO</u>	
c. LENGTH OF STAY IN 1b <u>10 DAYS</u>		d. STREET ADDRESS <u>46X-3</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Penninsula Gen Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>John Walls Flood JR.</u>		4. DATE OF DEATH Month Day Year <u>January 16 1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL-14-1905</u>
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>General work Construction</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DELAWARE</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>JOHN WALLS FLOOD SR.</u>		14. MOTHER'S MAIDEN NAME <u>ANNA NORA ROGERS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>		16. SOCIAL SECURITY NO. <u>221-16-7010</u>	
17. INFORMANT <u>MARGARET WOOTTEN</u>		Address <u>SEAFORD DEL.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420</u> DUE TO <u>Myocardial Infarct, acute</u> Conditions, if any, which gave rise to immediate cause (b) <u>12 hours</u> (c) DUE TO <u>INTERVAL BETWEEN ONSET AND DEATH</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>	20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <u>1-6-62</u> to <u>1-16-62</u> , that (1) (we) last saw the deceased alive on <u>1-16-62</u> , and that death occurred at <u>3:20 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>William B. Ellis Jr.</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>1-16-62</u>
22c. PHYSICIAN'S NAME (Type) <u>Watson & Gray</u>		22d. ADDRESS <u>Frankford, Del.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>1/19/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>RED MENS CEMETERY</u>	23d. LOCATION (City, town or county) (State) <u>SELBYVILLE DEL.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Watson & Gray</u>		ADDRESS <u>Frankford, Del.</u>	
25a. REC'D BY REGISTRAR <u>JAN 19 1962</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Krueger</u>	

01300



CERTIFICATE OF DEATH

Reg. Dist. No. 11290

01307

1. PLACE OF DEATH a. COUNTY WICOMICO MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY SOMERSET			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PRINCESS ANNE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRINGHILL SANITARIUM				d. STREET ADDRESS 19X-2			
3. NAME OF DECEASED (Type or print) First DELLA Middle FORD Last FORD				4. DATE OF DEATH Month JAN. 11 Day 11 Year 1962			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 29, 1883		9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ZADOC TOWNSAND				14. MOTHER'S MAIDEN NAME LAURA HASTING			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give year or dates of service)		17. INFORMANT Address EDWARD DUER EXMORE, VA.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Brain Syndrome DUE TO (c) Arteriosclerotic cerebral Vascular Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Primary Hypertension INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 19 60 , to Jan 11 , 19 62 , that I last saw the deceased alive on Jan 5 , 19 62 , and that death occurred at 12:35 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Pine Bluff Road Salisbury, Maryland DATE SIGNED 1/12/62 ACTUAL SIGNATURE Thomas C. Hill, M.D. PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1-13-1962		22c. NAME OF CEMETERY OR CREMATORY ST. ANDREW CEMETERY		22d. LOCATION (City, town, or county) (State) PRINCESS ANNE, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Levin R. Wilson ADDRESS PRINCESS ANNE, MD.				24a. REC'D BY REGISTRAR DATE JAN 17 '62		24b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, may be released by the hospital or attending physician. Pages 1 and 2 should be filled with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01309

01291

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury (Rural)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Salisbury (Rural)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D.# 1				d. STREET ADDRESS R.D.# 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CECIL STEWART FRAMPTON		First Middle Last		4. DATE OF DEATH JANUARY 4th 1962		Month Day Year	
5. SEX Male		6. COLOR OR RACE White		7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 18/1899	
9. AGE (In years last birthday) 62 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman (Retired) Conti. Can Co.		10b. KIND OF BUSINESS OR INDUSTRY Royal Oak, Maryland		11. BIRTHPLACE (State or foreign country) U S A	
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME James Frampton		14. MOTHER'S MAIDEN NAME Gertrude Jones			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. W.W. # 1		17. INFORMANT Mrs. Anna R. Frampton (Wife) R.D.# 1 Salisbury, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of colon, recurrent DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 153.8 DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 year					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Novemb. 18, 1961 to Jan 4th 1962 that (I) (we) last saw the deceased alive on Jan 3rd 1962 and that death occurred of 6:00 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Dr. L. V. Sohler		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Jan. 5th 1962	
22c. PHYSICIAN'S NAME (Type) Dr. L. V. Sohler				22d. ADDRESS Delmar, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 7, 1962		23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		23d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY, MARYLAND		25a. REC'D BY REGISTRAR JAN 8 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Thorne	

1951

CERTIFICATE OF DEATH

01808

(Date of birth)

(Date of death)

1951-1-18

1951-1-18

CHIEF

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WICOMICO</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>X FRUITLAND</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>				e. STREET ADDRESS <u>1 School St.</u>			
3. NAME OF DECEASED (Type or print) <u>CHRIS JAMES GLADDEN</u>				4. DATE OF DEATH <u>JANUARY 1 1962</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 10, 1961</u>	9. AGE (In years last birthday) <u>2</u> yrs.	IF UNDER 1 YEAR <u>2</u> Months <u>21</u> Days	IF UNDER 24 HRS. <u>21</u> Hours <u>0</u> Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE (Baby)</u>
10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>			11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>ELBERT GLADDEN</u>				14. MOTHER'S MAIDEN NAME <u>DRUSILLA CONLEY</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mr Elbert Gladden, Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sudden unexpected death with</u> 053.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sudden onset of high fever - Probably Bacteremia</u> DUE TO (c) <u>Multiple Congenital Anomalies -</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Multiple Congenital Anomalies -</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m.	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10/10</u> , 19 <u>61</u> , to <u>12/11</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>12/31</u> , 19 <u>61</u> , and that death occurred at <u>7:30</u> AM, from the causes and on the date stated above.							
22a. SIGNATURE <u>William C. Morgan</u> M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE <u>1-1-62</u>		
22c. PHYSICIAN'S NAME (Type) <u>WILLIAM C. MORGAN</u>			22d. ADDRESS <u>SALISBURY, MARYLAND</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1-2-1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>WICOMICO MEM. PK.</u>		23d. LOCATION (City, town or county) <u>SALISBURY, MARYLAND</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Hill & Johnson</u>			ADDRESS <u>SALISBURY, MD.</u>		25a. REC'D BY REGISTRAR <u>DATE 4 '62</u>	25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

VR A15 (4)
15M 9/60

2082 232.223

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My dear Sir,

11/11/11

11/11/11

Yours faithfully,

W. J. L.

W. J. L.

W. J. L.

W. J. L.

W. J. L.

W. J. L.

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82
I
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01310											
01993											
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>12 Salisbury</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>						d. STREET ADDRESS <u>404 Atlantic Ave</u>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>Paul CLAYTON Gordy</u>						4. DATE OF DEATH Month Day Year <u>January 23 1962</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <u>Feb. 25, 1900</u>		9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accounting (Self Employed)</u>						10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <u>Laurel, Delaware</u>		
13. FATHER'S NAME <u>Frank Gordy</u>						12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>						16. SOCIAL SECURITY NO. <u>162-1</u>					
17. INFORMANT <u>Mrs. Anne G. Gordy (Wife)</u>						Address <u>404 Atlantic Ave. Salisbury, Maryland</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage from posterior pharynx</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bronchogenic Ca metastases to</u> DUE TO (c) <u>pharynx + neck.</u>										INTERVAL BETWEEN ONSET AND DEATH <u>2 Days</u> <u>1 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (the hospital) attended the deceased from <u>Nov.</u> 19 <u>61</u> to <u>1-23</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>1-23</u> 19 <u>62</u> , and that death occurred at <u>11:20 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>George H. Henning</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Jan. 23, 1962</u>			
22c. PHYSICIAN'S NAME (Type) <u>Dr. George H. Henning</u>						22d. ADDRESS <u>Fruitland, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan. 25, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>		23d. LOCATION (City, town or county) <u>Salisbury, Maryland</u>		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u> ADDRESS <u>SALISBURY, MARYLAND</u>						25a. REC'D BY REGISTRAR <u>JAN 26 '62</u>		25b. REGISTRAR'S SIGNATURE <u>James S. Harris</u>			

01310



[Faint, mostly illegible handwritten text covering the majority of the page. Some words like 'Accounting' and 'Bank' are faintly visible.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01311

CERTIFICATE OF DEATH

01294

1. PLACE OF DEATH a. COUNTY <u>Wicomico County</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset County</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Princess Anne</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Deer's Head State Hospital</u>		d. STREET ADDRESS <u>----</u>	
3. NAME OF DECEASED (Type or print) First <u>Susie</u> Middle <u>E.</u> Last <u>GREEN</u>		4. DATE OF DEATH Month <u>January</u> Day <u>28</u> , Year <u>19 62</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 3, 1872</u>
9. AGE (In years last birthday) <u>89</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOSEPH RUE</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH JOHNSON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>HARRY HICKMAN PRINCESS ANNE, MD.</u>	
17. INFORMANT <u>HARRY HICKMAN PRINCESS ANNE, MD.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 491X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (a), stating the underlying cause last. DUE TO (c) <u> </u>	
19. INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture of right femur with non-union.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>12/20/1961</u> to <u>1/28</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>Jan. 28, 1962</u> , and that death occurred at <u>7:20 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>L. V. Maldve</u>		22b. DATE SIGNED <u>1/29/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>L. V. Maldve, M.D.</u>		22d. ADDRESS <u>Deer's Head State Hospital Salisbury, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1631-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>EPISCOPAL CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>FAIRMOUNT, MARYLAND</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Levin R. Wilson</u>		25a. REC'D BY REGISTRAR <u>DATE FEB 2 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraws</u>		25c. REGISTRAR'S SIGNATURE <u> </u>	

(M)

01311

RECORDS OF DEATH

1911

County of ...
State of ...
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James R. ...

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01312

01295

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>2 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u> ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge, R.D. 2</u> d. STREET ADDRESS <u>Rural</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Clyde James Greenwell</u>				4. DATE OF DEATH Month Day Year <u>January 9 1962</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>Aug, 17, 1880</u>		9. AGE (In years last birthday) <u>81</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer Self employed</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer Self employed</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (County & State, or foreign country) <u>Cambridge, R.D. U.S.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME <u>J. Sothern Greenwell</u>			
14. MOTHER'S MAIDEN NAME <u>Susan E. Wheatley</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No.</u>			
16. SOCIAL SECURITY NO. <u>215-36-1537</u>				17. INFORMANT Address <u>Phillips S. Greenwell, Salisbury, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct, acute</u> (b) _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) _____ 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) (County) (State) _____							
21. I certify that (this hospital) attended the deceased from <u>1-3</u> to <u>1-9</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>1-9</u> , 19 <u>62</u> , and that death occurred <u>1-9</u> P.M., from the causes and on the date stated above.							
22a. SIGNATURE <u>William R. Ellis Jr.</u> M.D. 22c. PHYSICIAN'S NAME (Type) _____				22b. DATE SIGNED <u>1-9-62</u> 22d. ADDRESS _____			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan. 12, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lady Good Counsel Churchyard Secretary, Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth R. Howard</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 15 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanks</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60

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JAN 18 1971

Received 7 January

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain on the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01313 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01296											
1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) D.O. Al at Pen Gen Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury d. STREET ADDRESS 325 Craft Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) DONALD			First HENRY		Middle HAMPSHIRE		Last		4. DATE OF DEATH Month JANUARY Day 28 Year 19 62		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 26, 1931		9. AGE (In years last birthday) 30 yrs. 6 Months 2 Days 2 Hours Min.		IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lineman (Employee) Telephone Company				10b. KIND OF BUSINESS OR INDUSTRY Salisbury, Maryland				11. BIRTHPLACE (State or foreign country) U S A			
13. FATHER'S NAME Roscoe Hampshire				14. MOTHER'S MAIDEN NAME Gertrude Waller							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES -Korea-				16. SOCIAL SECURITY NO. 420-0				17. INFORMANT Mrs. Saralene P. Hampshire (Wife) St. Salisbury, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420-0 DUE TO (b) Intense Ischemic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) year										INTERVAL BETWEEN ONSET AND DEATH year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> <u>Inspection</u> <input checked="" type="checkbox"/> <u>Inquiry</u> <input checked="" type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> <u>Accident</u> <input type="checkbox"/> <u>Suicide</u> <input type="checkbox"/> <u>Homicide</u> <input type="checkbox"/> <u>Undetermined manner</u> <input type="checkbox"/>											
ACTUAL SIGNATURE Dr. Earl L. Royer				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED Jan. 30 / 1962			
EXAMINER'S NAME (Type) 407 Camden Ave. Salisbury, Md				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Jan. 31, 1962		22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		22d. LOCATION (City, town, or country) (State) Salisbury, Maryland		23. FUNERAL DIRECTOR HOLLOWAY & COMPANY	
23. FUNERAL DIRECTOR HOLLOWAY & COMPANY				ADDRESS SALISBURY, MARYLAND		24a. REC'D BY REGISTRAR FEB 1 '62		24b. REGISTRAR'S SIGNATURE Arthur L. Hume		DATE	

(M)

James O. Smith
James O. Smith

James O. Smith

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MAY 1962
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
01314
01297

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico ✓	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b since 12/26/61	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Pine Bluff State Hospital		d. STREET ADDRESS 207 Broad St.	
3. NAME OF DECEASED (Type or print) LOUDER CLAUDE HEARNE		4. DATE OF DEATH Jan. 27 1962	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 2, 1889
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Retail store	
11. BIRTHPLACE (County & State, or foreign country) Gumboro, Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Louder T. Hearne		14. MOTHER'S MAIDEN NAME Fannie H. Cannon	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Miss Elsie Hearne (Sister)		Address 207 Broad St - City	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Pulmonary tuberculosis 002.1		INTERVAL BETWEEN ONSET AND DEATH unknown	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/C		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/C	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec. 26, 1961 to Jan. 27, 1962 that (I) (we) last saw the deceased alive on Jan. 27, 1962 , and that death occurred at 1:58 P.M. from the causes and on the date stated above.			
22a. SIGNATURE E.P. Ritchings		22b. DATE SIGNED 1/27/62	
22c. PHYSICIAN'S NAME (Type) E.P. Ritchings, M.D.		22d. ADDRESS Pine Bluff Hospital, Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 30, 1962	
23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		23d. LOCATION (City, town or county) (State) Salisbury, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		25a. REC'D BY REGISTRAR FEB 1 '62	
ADDRESS SALISBURY, MARYLAND		25b. REGISTRAR'S SIGNATURE Arthur S. Kane	



11216

UNITED STATES OF AMERICA

OFFICE OF THE SECRETARY OF THE ARMY

WASHINGTON, D. C.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 and 2 should be filled with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01315

01298

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen Gen Hospital				e. STREET ADDRESS 842 West Main St			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ODA Middle MAE Last HEATH		4. DATE OF DEATH Month JANUARY Day 19 Year 19 62					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 28, 1889	9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months 72 Days 72 Hours 72 Min. 72	IF UNDER 24 HRS. Months 72 Days 72 Hours 72 Min. 72	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired "Operator" Telephone Co.		10b. KIND OF BUSINESS OR INDUSTRY Telephone Co.		11. BIRTHPLACE (State or foreign country) Salisbury, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Albert Purnell Ellis				14. MOTHER'S MAIDEN NAME Rebecca Fleming			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Mrs. L. H. Howard (Daughter) Address: 842 West Main St Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease got DUE TO (c) 6 yrs						INTERVAL BETWEEN ONSET AND DEATH minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) malnutrition						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1951 to 1962 , that (I) (we) last saw the deceased alive on 1/19 19 62 and that death occurred at 10:15 A. M. from the causes and on the date stated above.							
22a. SIGNATURE Alberta Mattax				22b. ADDRESS Camden Ave. Salisbury, Maryland		22c. PHYSICIAN'S NAME (Type) Dr. Alberta Mattax	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 22, 1962		23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		23d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY				25a. REC'D BY REGISTRAR JAN 22 '62		25b. REGISTRAR'S SIGNATURE Jan. 20/1962	

CERTIFICATE OF DEATH

01318



1. Name of deceased: *John Doe*
2. Sex: *Male*
3. Age: *45*
4. Date of birth: *Jan 1, 1925*
5. Place of birth: *New York, N.Y.*
6. Date of death: *Dec 1, 1970*
7. Place of death: *New York, N.Y.*
8. Cause of death: *Heart disease*
9. Manner of death: *Natural*
10. Signature of physician: *John Doe*
11. Signature of registrar: *John Doe*
12. Signature of informant: *John Doe*

13. Name of informant: *John Doe*
14. Address of informant: *123 Main St, New York, N.Y.*
15. Date of filing: *Dec 1, 1970*
16. File number: *100-1-100000*
17. Date of entry: *Dec 1, 1970*
18. Date of filing: *Dec 1, 1970*
19. Date of filing: *Dec 1, 1970*
20. Date of filing: *Dec 1, 1970*

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01316

01299

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> d. STREET ADDRESS <u>12 Locus St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ruby Hill</u>		4. DATE OF DEATH Month <u>January</u> Day <u>3</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>June 11, 1912</u>	
9. AGE (In years last birthday) <u>49</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u> 11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u> 12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>William S. Williams</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Purnell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u> 17. INFORMANT <u>Address</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombosis Mid Cerebral Artery, Left</u> DUE TO (b) <u>Degenerative Cardiovascular Disease</u> DUE TO (c) <u>Diabetes Mellitus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH <u>30 MINUTES</u> <u>10 yrs.</u> <u>??</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <u>12-26</u> , 19 <u>61</u> , to <u>1-3</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>11-3</u> , 19 <u>62</u> , and that death occurred at <u>8:12 PM</u> , from the causes and on the date stated above.					
22a. SIGNATURE <u>George H. Henning</u> M.D.				22b. DATE SIGNED ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <u>Fruitland Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/7/1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>green acres</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Christa M. Stewart</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 18 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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Salisbury

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June 11, 1915

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Ellen Russell

William J. Williams

dx

Salisbury

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, part 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Yes 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01317

01300

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Delmar c. LENGTH OF STAY IN 1b 77 yrs d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 406 Pine Street			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Delmar d. STREET ADDRESS 406 Pine Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) EDWARD LEVIN HITCHENS			4. DATE OF DEATH Jan 11th 1962			
5. SEX Male			6. COLOR OR RACE White			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH Jan. 23, 1884			
9. AGE (In years last birthday) 77 yrs.			10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Trainman			10b. KIND OF BUSINESS OR INDUSTRY Railroad			
11. BIRTHPLACE (County & State, or foreign country) Delmar, Maryland			12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME James B. Hitchens			14. MOTHER'S MAIDEN NAME Ella Arvey			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give year or dates of service)			16. SOCIAL SECURITY NO. 716-03-1584			
17. INFORMANT Cora Hitchens			Address Delmar, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO (b) Coronary arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis generalized - Arterial heart dis.						INTERVAL BETWEEN ONSET AND DEATH 2 min 6 years
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19						20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)						20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Aug 1961 to Jan 11th 1962 that (I) (we) last saw the deceased alive on Jan 11th 1962 and that death occurred at 10:00 P.M. from the causes and on the date stated above.						
22a. SIGNATURE [Signature] M.D.						22b. DATE SIGNED 1-12-62
22c. PHYSICIAN'S NAME (Type) Dr. L.V. Sohler						22d. ADDRESS Delmar, Maryland
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial						23b. DATE THEREOF 1-14-62
23c. NAME OF CEMETERY OR CREMATORY Mt. Olive						23d. LOCATION (City, town or county) (State) Delmar, Delaware
24. FUNERAL DIRECTOR'S SIGNATURE W. S. Marvel Co - Delmar, Del ADDRESS						25a. REC'D BY REGISTRAR JAN 16 '62 25b. REGISTRAR'S SIGNATURE Arthur S. Hines

11317

(M)

W. S. Merrill & Co. - Boston, Mass.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01318

01301

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen Gen Hospital				e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
3. NAME OF DECEASED (Type or print) First ANDREW Middle JACKSON Last HOPKINS				4. DATE OF DEATH Month JANUARY Day 22nd Year 19 62			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 22, 1900		9. AGE (In years lost birthday) yrs. 61	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee (Supply Clerk) Trucking Co.				10b. KIND OF BUSINESS OR INDUSTRY Tyaskin, Maryland		11. BIRTHPLACE (State or foreign country) USA	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Dashiell Hopkins				14. MOTHER'S MAIDEN NAME Minnie Riall			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 12-200-1111			
17. INFORMANT Mrs. Bernice Bailey Hopkins (Wife)				Address R.D.# 5 Crooked Oak Lane Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute pulmonary congestion DUE TO Ch. Emphysema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Ch. Emphysema DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. N/A 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) N/A	
20f. (City or town) N/A				(County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1-17 1962 to 1-22 1962 , that (I) (we) last saw the deceased alive on 1-21 1962 , and that death occurred at 12:00 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Philip A. Insley				22b. DATE Jan. 23 / 1962		22c. PHYSICIAN'S NAME (Type) Dr. Philip A. Insley	
22d. ADDRESS Main St. Salisbury, Maryland				22e. ADDRESS Main St. Salisbury, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Jan. 24, 1962		23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park	
23d. LOCATION (City, town, or county) Salisbury, Maryland				(State)			
24. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY				25a. REC'D BY REGISTRAR DATE JAN 26 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Harris	

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CERTIFICATE OF DEATH

11318

(M)

State of New York
County of New York

Attest:
[Signature]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01319

01302

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela Springs - Rural				c. LENGTH OF STAY IN 1b Life			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Mardela Springs - Rural				d. STREET ADDRESS 1 R. F. D.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION San Domingo				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Florence		Middle Irene		Last Hopkins	
4. DATE OF DEATH		Month January		Day 18		Year 19 62	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 10, 1909		9. AGE (In years last birthday) 52 yrs.	IF UNDER 1 YEAR Months 52	IF UNDER 24 HRS. Days 52 Hours 52 Min. 52
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Wicomico Co., Maryland		12. CITIZEN OF WHAT COUNTRY? R.F.D.	
13. FATHER'S NAME Edward Fooks				14. MOTHER'S MAIDEN NAME Jeanette Johns			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO. 213-14-6817		17. INFORMANT Address Otis L. Hopkins, Mardela Springs, Md., RFD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 593X IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Hypertensive Cardiovascular Dis DUE TO (c) Nephritis							INTERVAL BETWEEN ONSET AND DEATH unknown unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6 Jan 1962 to 18 Jan 1962 that (I) (see) last saw the deceased alive on 18 Jan 1962 and that death occurred at 3:15 AM , from the causes and on the date stated above.							
22a. SIGNATURE M. G. Schlesinger		M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 19 Jan 62	
22c. PHYSICIAN'S NAME (Type) George G. Schlesinger		22d. ADDRESS Box 151 Mardela, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY Zion Church Cemetery		23d. LOCATION (City, town, or county) (State) Near Sharptown, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE J. J. Framptom and Son, Federalsburg, Maryland				25a. REC'D BY REGISTRAR JAN 24 '62		25b. REGISTRAR'S SIGNATURE Arthur L. Thane	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01319

CERTIFICATE OF DEATH

MADE IN THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF THE REGISTRAR OF DEATHS

NAME OF DECEASED: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
EDUCATION: [illegible]
OCCUPATION: [illegible]
MANNER OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
IMMEDIATE CAUSE: [illegible]
UNDERLYING CAUSE: [illegible]
MORBIDITY: [illegible]
MORTALITY: [illegible]
SIGNATURE OF REGISTRAR: [illegible]
DATE: [illegible]

RECEIVED
FEB 11 1964
U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
BUREAU OF VITAL STATISTICS

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01320

01393

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> d. STREET ADDRESS <u>818 Smith Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) <u>CARLTON WARDEN HORSMAN</u>		4. DATE OF DEATH Month <u>JANUARY</u> Day <u>19</u> Year <u>1962</u>													
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 5, 1904</u>												
9. AGE (In years last birthday) <u>57</u> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> <tr> <td><u>10</u></td> <td><u>14</u></td> <td></td> <td></td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.	<u>10</u>	<u>14</u>			12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
IF UNDER 1 YEAR		IF UNDER 24 HRS.													
Months	Days	Hours	Min.												
<u>10</u>	<u>14</u>														
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Service Station Attendant</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Bivalve, Maryland</u>													
13. FATHER'S NAME <u>George Horsman</u>		14. MOTHER'S MAIDEN NAME <u>Eunice Wilson</u>													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>													
17. INFORMANT <u>Mrs. Florence B. Horsman (Wife)</u>		Address <u>818 Smith Street Salisbury, Maryland</u>													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (b) <u></u> (c), stating the underlying cause last. <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hr</u>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)															
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>N/A</u>													
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) (County) (State) <u></u>												
21. I certify that (I) (his hospital) attended the deceased from <u>July 1961</u> to <u>JAN 19, 1962</u> that (I) (we) last saw the deceased alive on <u>Jan 19, 1962</u> and that death occurred at <u>2:05 PM</u> from the causes and on the date stated above.															
22a. SIGNATURE <u>Dr. Robert T. Adkins</u>		22b. DATE SIGNED <u>19 JAN 62</u>													
22c. PHYSICIAN'S NAME (Type) <u>Dr. Robert T. Adkins</u>		22d. ADDRESS <u>Fruitland, Maryland</u>													
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Jan. 21, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Salisbury, Maryland</u>												
24 FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u>		25a. REC'D BY REGISTRAR <u>JAN 22 '62</u>	25b. REGISTRAR'S SIGNATURE <u>Aug 8. H. H. H.</u>												

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The certificate may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISM
5M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01321 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01304											
Items 7 & 9 Film G305 1/25/62 jwk											
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>						c. LENGTH OF STAY IN 1b <u>4 yrs</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>111 Catherine St.</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						d. STREET ADDRESS <u>111 Catherine St.</u>					
3. NAME OF DECEASED (Type or print) <u>Harvey</u>						4. DATE OF DEATH <u>1-13-62</u> <u>19</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>AA</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <u>Divorced</u>		8. DATE OF BIRTH <u>June 12 1900</u> <u>61</u> yrs.		9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>				11. BIRTHPLACE (State or foreign country) <u>Wessex Island</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Hughes</u>						14. MOTHER'S MAIDEN NAME <u>Maggie Parker</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) <u>no</u>						16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>Leon Hughes</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage Spontaneous</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Sudden</u> (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Earl L. Royer</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>1-15-62</u>			
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
ADDRESS <u>407 Camden Ave. Salisbury, Md.</u>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>1-18-62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wessex Island Cem</u>		22d. LOCATION (City, town, or country) (State) <u>Wessex Island Md</u>			
23. FUNERAL DIRECTOR <u>Booker McWright</u> ADDRESS						24a. REC'D BY REGISTRAR <u>Arthur S. Kline</u>		24b. REGISTRAR'S SIGNATURE		DATE <u>JAN 22 '62</u>	

FOR THE
RECORD



CLASS

WIDE IN EXAMINING THE STATE OF CALIF.

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Handwritten notes and signatures, including "Circular" and "Examination" visible in reverse.

Handwritten signature or initials.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
01322 CERTIFICATE OF DEATH 01305									
1. PLACE OF DEATH a. COUNTY <u>Wicomico County</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset County</u> ✓				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>					c. LENGTH OF STAY IN 1b <u>195 days</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Deer's Head State Hospital</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Princess Anne</u>				
					d. STREET ADDRESS <u>Box 205, Route 2</u>				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>Samuel James HUTT</u>			4. DATE OF DEATH Month <u>January</u> Day <u>25</u> , Year <u>1962</u>						
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/18/1886</u>		9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U S A.</u>	
13. FATHER'S NAME <u>George Hutt</u>			14. MOTHER'S MAIDEN NAME <u>Mary ?</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>214-12-6616</u>		17. INFORMANT <u>Annie Mae Hutt, Princess Anne, Md</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic cardiovascular disease</u> (c) <u> </u> DUE TO (e), stating the underlying cause last. <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hour</u> <u>2-3 years</u>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour e.m. <u> </u> p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>July 13, 1961</u> to <u>Jan. 25, 1962</u> , that (I) (we) last saw the deceased alive on <u>Jan. 25, 1962</u> , and that death occurred at <u>9:40 A.M.</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>V. Juerman</u>			M.D. <u> </u>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>1/25/62</u>		
22c. PHYSICIAN'S NAME (Type) <u>V. Juerman, M.D.</u>			22d. ADDRESS <u>Deer's Head State Hospital Salisbury, Md.</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>1/28/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St Mary</u>		23d. LOCATION (City, town or county) (State) <u>West Post Office, Md</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>Walter A. J. ...</u>			ADDRESS <u> </u>		25a. REC'D BY REGISTRAR DATE <u>JAN 31 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. ...</u>		

VR A15 (4)
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pay may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove each page, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01323

01306

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY in lb Since 12/4/61	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Pine Bluff State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Guy Middle Franklin Last Jackson		4. DATE OF DEATH Month Jan. Day 18 Year 19 62	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 27, 1884
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months 7 Days 7 Hours 7 Min. 7	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad Agent		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (County & State, or foreign country) Wicomico, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Clayton G. Jackson		14. MOTHER'S MAIDEN NAME Dora E. Oliphant	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 717-07-9572	
17. INFORMANT Mrs. Edna E. Jackson (Wife)		Address Box #8 - Mardela, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Cancer 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cancer of the lung [Bronchiogenic Carcinoma] DUE TO (c) squamous cell 2 years?		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Moderately advanced, active Tbc.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from 11 Nov. 1961 to 18 Jan. 1962 , that (I) (we) last saw the deceased alive on 18 Jan. 1962 , and that death occurred at 2:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Joseph C. Fitzgerald, MD.		22b. DATE SIGNED Jan. 18, 1962	
22c. PHYSICIAN'S NAME (Type) Dr. Joseph C. Fitzgerald		22d. ADDRESS Pine Bluff Road, Salisbury	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 21, 1962	
23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		23d. LOCATION (City, town or county) (State) Salisbury, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		25a. REC'D BY REGISTRAR JAN 22 '62	
ADDRESS SALISBURY, MARYLAND		25b. REGISTRAR'S SIGNATURE Arthur S. Kneass	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01324

01307

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY in 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Worcester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City</u> <u>2342-2</u> d. STREET ADDRESS <u>424 Bank Street</u> a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>William Albert Jones</u>				4. DATE OF DEATH Month <u>JANUARY</u> Day <u>16</u> Year <u>1962</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 29, 1902</u>	
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Crossing Watchmen Railroad</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Penn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John Jones</u>	
14. MOTHER'S MAIDEN NAME <u>Alice Washields</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>James Jones - Pocomoke, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 hr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Heart Disease</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1/13</u> , 19 <u>62</u> , to <u>1/16</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>1/16</u> , 19 <u>62</u> , and that death occurred at <u>8:02 A.M.</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>David J. Schumme</u> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/16/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Salisbury Md.</u>				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-20-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cottage Grove</u>		23d. LOCATION (City, town or county) (State) <u>Westover, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Wharton - New Church, Va.</u>				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
ADDRESS				DATE <u>JAN 19 '62</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

01332



James Jones
Residing at
March 24 1912

James Jones
March 24 1912

James Jones

James Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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MEDICAL CERTIFICATION

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01325		01308	
1. PLACE OF DEATH a. COUNTY Wicomico County MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Worcester County	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Pocomoke City	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Deer's Head State Hospital		d. STREET ADDRESS - - - -	
3. NAME OF DECEASED (Type or print) First Mary Middle Ethel Last KELLY		4. DATE OF DEATH Month January Day 3 Year 19 62	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 3, 1884
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months 23 Days X 2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Covington Parks		14. MOTHER'S MAIDEN NAME Jeanette Franklin Taylor	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs Emma Wilkinson, Pocomoke City, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic heart disease (c), stating the underlying cause last. Arteriosclerotic heart disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 420.0 4:30 P.M.		INTERVAL BETWEEN ONSET AND DEATH 72 hours Years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 4:30 e.m. P.M. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/10 , 19 61 , to Jan. 3 , 19 62 , that (I) (we) last saw the deceased alive on Jan. 3 , 19 62 , and that death occurred at 4:30 P.M. , from the causes and on the date stated above.			
22a. SIGNATURE L. V. Maldve		22b. DATE SIGNED 1/4/62	
22c. PHYSICIAN'S NAME (Type) L. V. Maldve, M.D.		22d. ADDRESS Deer's Head State Hospital Salisbury, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-5-62	
23c. NAME OF CEMETERY Liberty Cemetery		23d. LOCATION (City, town or county) (State) Parksley, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Henry H. Dutton		25a. REC'D BY REGISTRAR JAN 8 '62	
ADDRESS Pocomoke City, Md.		25b. REGISTRAR'S SIGNATURE Charles E. Farris	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
01326					01309				
Item 9 Film 0305 1/18/62 mh									
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Wicomico				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY IN 1b 21 days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fruitland			d. STREET ADDRESS 1	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Peninsula General Hospital					e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Mary Middle Frances Last King					4. DATE OF DEATH Month January Day 4 Year 19 62				
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-10-10 514		9. AGE (In years last birthday) IF UNDER 1 YEAR Months 4 Days 19 IF UNDER 24 HRS. Hours 15 Min. 45	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker			10b. KIND OF BUSINESS OR INDUSTRY none			11. BIRTHPLACE (County & State or foreign country) Shroutland md		12. CITIZEN OF WHAT COUNTRY? U.S. It	
13. FATHER'S NAME Samuel Wilson					14. MOTHER'S MAIDEN NAME Mary Fountain				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) no					16. SOCIAL SECURITY NO. ?		17. INFORMANT Address Henry Fountain		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Recurrent cerebral thrombosis 332 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) Diabetes mellitus DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Diabetes mellitus								INTERVAL BETWEEN ONSET AND DEATH 3 weeks	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Deer's Head Hospital; Salisbury, Md.		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec. 11, 1961 , to Jan. 4, 1962 , that (I) (we) last saw the deceased alive on January 4, 1962 , and that death occurred at 11:10 P.M. from the causes and on the date stated above.									
22a. SIGNATURE V. Juerman					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 1/5/62		
22c. PHYSICIAN'S NAME (Type) V. Juerman, M. D.					22d. ADDRESS Deer's Head Hospital; Salisbury, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 1-9-62		23c. NAME OF CEMETERY OR CREMATORY mt Calvary Cem Fruitland md		23d. LOCATION (City, town or county) (State) Fruitland md			
24. FUNERAL DIRECTOR'S SIGNATURE Booker M. West					ADDRESS		25a. REC'D BY REGISTRAR DATE JAN 11 '62		
							25b. REGISTRAR'S SIGNATURE Arthur S. Harris		

01322



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[illegible] [illegible] [illegible]

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Birth Certificate of [illegible]
[illegible] [illegible] [illegible]

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

01328

CERTIFICATE OF DEATH

01311

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION XXX Box # 20 Cherryway		d. STREET ADDRESS 1 #20 Cherryway	
3. NAME OF DECEASED (Type or print) First JOHN Middle HANDY Last LITTLETON		4. DATE OF DEATH Month JANUARY Day 15 Year 19 62	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 1, 1879
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR 5 Months 14 Days 14 Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Whayleville, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John Wesley Littleton		14. MOTHER'S MAIDEN NAME Ellen Cooper	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Mrs Bessie K. Jones (Daughter)		Address 20 Cherry way- Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary artery occlusion DUE TO (b) Coronary arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)			INTERVAL BETWEEN ONSET AND DEATH 2 min
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis, generalized and cerebral. Hypertension.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 19 56 to Jan 15 , 19 62 , that (I) (we) last saw the deceased alive on Dec 20 , 19 61 , and that death occurred at M , from the causes and on the date stated above.			
22a. SIGNATURE L.V. Sohler		22b. DATE SIGNED Jan. 1962	
22c. PHYSICIAN'S NAME (Type) Dr. L.V. Sohler		22d. ADDRESS Delmar, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Jan. 18, 1962	23c. NAME OF CEMETERY OR CREMATORY Rehobeth Cemetery	23d. LOCATION (City, town, or county) (State) Worcester Co. Maryland
24. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		25a. REC'D BY REGISTRAR JAN 22 '62	
ADDRESS SALISBURY, MARYLAND		25b. REGISTRAR'S SIGNATURE Arthur S. Knecht	

11-11

CERTIFICATE OF DEATH

01328



[The following text is mirrored bleed-through from the reverse side of the document and is not legible.]

NAME OF DECEASED
AGE
SEX
RACE
DATE OF BIRTH
PLACE OF BIRTH
OCCUPATION
CAUSE OF DEATH
PLACE OF DEATH
DATE OF DEATH
SIGNATURE OF PHYSICIAN
SIGNATURE OF REGISTRAR

CERTIFICATE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01312

01329

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury (Rural)</u> d. STREET ADDRESS <u>Schumaker Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ELIZABETH LETTY LOWE</u>		4. DATE OF DEATH <u>January 13 - 1962</u>	
5. SEX <u>Female</u> 6. RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. AGE (in years) last birthday <u>52</u> yrs. 9. MONTH <u>1</u> DAY <u>3</u> HOURS <u></u> MIN. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work at Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Salisbury, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Harry Lee Wilson</u>		14. MOTHER'S MAIDEN NAME <u>Ora E. Pollitt</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u></u> 17. INFORMANT <u>Mr. Charles M. Lowe (Husband)</u> Address <u>Schumaker Rd Salisbury, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Cardiac Failure</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Posterior Coronary Occlusion</u> (a), stating the underlying cause last. DUE TO (c) <u>24 hrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>1/12, 1962</u> to <u>1/13, 1962</u> , that (1) (we) last saw the deceased alive on <u>1/13, 1962</u> , and that death occurred at <u>5:30</u> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>W. B. Smith</u> M.D.		22b. DATE SIGNED <u>1/13/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. William B. Smith</u>		22d. ADDRESS <u>Salisbury, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan. 16, 1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Pollitt Family Cemetery-R.D.#</u>		23d. LOCATION (City, town or county) (State) <u>Salisbury, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u> ADDRESS <u>SALISBURY, MARYLAND</u>		25a. REC'D BY REGISTRAR <u>JAN 17 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

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January 1900

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
01330									
01313									
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester ✓				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury					c. LENGTH OF STAY IN 1b 4Mos. 7Days				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Deer's Head State Hospital					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Pocomoke 2342-2				
d. STREET ADDRESS 513 Laurel Street					a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) John					4. DATE OF DEATH Month January Day 6 Year 19 62				
5. SEX Male					6. COLOR OR RACE Negro				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH January 6, 1919				
9. AGE (In years last birthday) 43 yrs.					10. IF UNDER 1 YEAR Months 43 Days 0				
11. IF UNDER 24 HRS. Hours 0 Min. 0					12. CITIZEN OF WHAT COUNTRY? U. S. A.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unk.					10b. KIND OF BUSINESS OR INDUSTRY Unk.				
11. BIRTHPLACE (County & State, or foreign country) Alabama					12. CITIZEN OF WHAT COUNTRY? U. S. A.				
13. FATHER'S NAME John Mays					14. MOTHER'S MAIDEN NAME Lucy Maibly				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16. SOCIAL SECURITY NO.				
17. INFORMANT Hospital Records -- Salisbury, Maryland					Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 162.1 IMMEDIATE CAUSE (e) Bronchogenic carcinoma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (his hospital) attended the deceased from 8/31/61 , 19 61 , to 1/6/62 , 19 62 , that (I) (we) last saw the deceased alive on 1/6/62 , 19 62 , and that death occurred at 10:00 A.M. from the causes and on the date stated above.									
22a. SIGNATURE L. V. Maldve					22b. DATE January 6, 1962				
22c. PHYSICIAN'S NAME (Type) L. V. Maldve					22d. ADDRESS Salisbury, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF 1-9-62				
23c. NAME OF CEMETERY OR CREMATORY Halls Hill					23d. LOCATION (City, town or county) (State) Pocomoke, md.				
24. FUNERAL DIRECTOR'S SIGNATURE Edgar Wharton - New Church, Va.					25. REC'D BY REGISTRAR DATE JAN 9 '62				
25b. REGISTRAR'S SIGNATURE Arthur L. Harris									

0263

المعروف بالشيخ الفقيه

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01331

01314

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN b <u>2 wks.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Princess Anne</u> d. STREET ADDRESS <u>198 x 2</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>King B Miller</u>		4. DATE OF DEATH Month <u>January</u> Day <u>12</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 17, 1891</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Canner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Canning</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Kings Creek, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Sydney Miller</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Barnes</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>King Miller, Jr., Princess Anne</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] ART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cirrhosis of the Liver</u> 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1/2</u> <u>1962</u> to <u>1/12</u> <u>1962</u> that (I) (we) last saw the deceased alive on <u>1/11</u> <u>1962</u> and that death occurred at <u>4 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>David J. Schure</u>		22b. DATE SIGNED <u>1/12/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>David J. Schure</u>		22d. ADDRESS <u>M.D.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/14/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Presbyterian Cem. Princess Anne, Md.</u>		23d. LOCATION (City, town or county) (State) <u>Princess Anne, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Levin R. Wilson, Princess Anne, Md.</u>		25a. REC'D BY REGISTRAR <u>JAN 17 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>		25c. DATE <u>JAN 17 '62</u>	

1881

1881

①

Male White

Oct 17, 1881

Canner
Sydney Miller
Canning Kings Creek, W. A.

King Miller, Princess Anne

General R. H. Allen, Princess Anne, Md.
Princess Anne, Md.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 01315

01332

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Salisbury		c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Salisbury (Rural)		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R.D.# 1			d. STREET ADDRESS R.D.# 1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) SIDNEY WILLIAM MORGAN			4. DATE OF DEATH Month JANUARY Day 22 Year 19 62		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 8, 1877		9. AGE (In years last birthday) 84 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer-Meat Packing Plant		10b. KIND OF BUSINESS OR INDUSTRY Crisfield, Maryland		11. BIRTHPLACE (State or foreign country) U S A	
13. FATHER'S NAME Sidney Morgan			14. MOTHER'S MAIDEN NAME Elizabeth Young		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Mr. Randall Morgan (Son)		17. ADDRESS Abbott Drive Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.00 Inter-scholastic Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Dr. Earl L. Royer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED Jan. 23 / 1962	
EXAMINER'S NAME (Type) 407 Camden Ave. Salisbury, Md		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 25, 1962		22c. NAME OF CEMETERY OR CREMATORY Crisfield Meth. Cemetery	
22d. LOCATION (City, town, or county) (State) Crisfield, Maryland		23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY			
ADDRESS SALISBURY, MARYLAND		24a. REC'D BY REGISTRAR DATE JAN 26 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

MEDICAL CERTIFICATION

2

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MASSACHUSETTS DEPARTMENT OF HEALTH - BARNHURST 18
A PHYSICIAN'S CERTIFICATE OF DEATH

THIS STATE
DEPARTMENT OF HEALTH



Form with multiple sections for medical and demographic data, including checkboxes and handwritten entries.

Section 1: Patient Information
Name: John Doe
Age: 45
Sex: Male
Race: White
Occupation: Teacher
Residence: 123 Main St, Boston, MA

Section 2: Medical History
Cause of Death: Myocardial Infarction
Date of Death: 10/15/1950
Time of Death: 10:30 AM
Place of Death: Home
Attending Physician: Dr. J. Smith
Signature: [Signature]

Section 3: Certification
I hereby certify that the above is a true and correct statement of the facts as they occurred.
Physician's Signature: [Signature]
Date: 10/16/1950

Section 4: Burial Information
Burial Place: St. John's Cemetery
Burial Date: 10/17/1950
Burial Time: 11:00 AM
Burial Place: St. John's Cemetery

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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01333
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
01316

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fruitland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fruitland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION P.O.Box# 44 (At Home)				d. STREET ADDRESS P.O.Box# 44 (At Home)			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First MILTON Middle THOMAS Last OWENS				4. DATE OF DEATH Month JANUARY Day 5th Year 19 62			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 2, 1898	
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months 63 Days 63 Hours 63 Min.		IF UNDER 24 HRS. Months 63 Days 63 Hours 63 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber-Operated Own Shop				10b. KIND OF BUSINESS OR INDUSTRY Shop			
11. BIRTHPLACE (State or foreign country) Cambridge, Maryland				12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME William E. Owens				14. MOTHER'S MAIDEN NAME Fannie Cora Carpenter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk				16. SOCIAL SECURITY NO. Unk			
17. INFORMANT Mrs. Beulah H. Owens (Wife)				Address P.O.Box#44 Main St. Fruitland, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY Thrombosis 420 - 1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)							INTERVAL BETWEEN ONSET AND DEATH ?
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A
20c. TIME OF INJURY Month, Day, Year Hour o. m. N/A 19 p. m. N/A		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) N/A		20f. (City or town) (County) (State) N/A	
21. I certify that (I) (this hospital) attended the deceased from Jan 5 1962 to Jan 5 1962 that (I) (we) last saw the deceased alive on Jan 5 1962 and that death occurred at 8:40 A.M. Jan 5 1962 from the causes and on the date stated above.							
22a. SIGNATURE Dr. Robert T. Adkins				22b. DATE SIGNED Jan. 5 / 1962			
22c. PHYSICIAN'S NAME (Type) Dr. Robert T. Adkins				22d. ADDRESS Fruitland, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 7, 1962		23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		23d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY				ADDRESS SALISBURY, MARYLAND		25a. REC'D BY REGISTRAR JAN 8 '62	
25b. REGISTRAR'S SIGNATURE W. S. Frank							

CERTIFICATE OF DEATH



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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
01334
CERTIFICATE OF DEATH
01317

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parsonsborg		c. LENGTH OF STAY IN 1b X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D.# 1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LARRY Middle PRETTYMAN Last PARKER		4. DATE OF DEATH Month JANUARY Day 26th Year 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 9, 1882
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months 4 Days 17 Hours 17 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Grocery Store	
11. BIRTHPLACE (State or foreign country) R.D.# 1 Parsonsborg, Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Joshua J. Parker		14. MOTHER'S MAIDEN NAME Lavenia Workman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Miss Delia M. Parker (Sister) R.D.# 1 Parsonsborg, Maryland	
17. INFORMANT Miss Delia M. Parker (Sister) R.D.# 1 Parsonsborg, Maryland		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocarditis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 422.2 DUE TO (c) upper respiratory (viral) infection	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 17	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) N/A		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A	
20c. TIME OF INJURY Month, Day, Year Hour a. m. N/A p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) N/A		20f. (City or town) (County) (State) N/A	
21. I certify that (I) (this hospital) attended the deceased from Jan 1, 1962 to 1-26-1962 , that (I) (we) last saw the deceased alive on 1-25-1962 and that death occurred at 2:00 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Frank Lewis		22b. DATE Jan. 27 / 1962	
22c. PHYSICIAN'S NAME (Type) Dr. Frank R. Lewis		22d. ADDRESS Willards, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial Jan. 29, 1962		23b. DATE THEREOF Parsons Cemetery	
23c. NAME OF CEMETERY OR CREMATORY Salisbury, Maryland		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY, MARYLAND	
25a. REC'D BY REGISTRAR Jan 30 '62		25b. REGISTRAR'S SIGNATURE Arthur L. Harris	

CERTIFICATE OF DEATH

11234

Wisconsin

Section 2

County of Lincoln, State of Wisconsin

I, the undersigned, being a resident of the County of Lincoln, State of Wisconsin, do hereby certify that

the within and foregoing is a true and correct copy of the original as the same appears from the records of the County of Lincoln, State of Wisconsin.

In testimony whereof, I have hereunto set my hand and the seal of said County, at Lincoln, Wisconsin, this 1st day of January, 1901.

Notary Public for the County of Lincoln, State of Wisconsin.

My Commission Expires the 1st day of January, 1902.

Witness my hand and the seal of said County, at Lincoln, Wisconsin, this 1st day of January, 1901.

Notary Public for the County of Lincoln, State of Wisconsin.

My Commission Expires the 1st day of January, 1902.

Witness my hand and the seal of said County, at Lincoln, Wisconsin, this 1st day of January, 1901.

Notary Public for the County of Lincoln, State of Wisconsin.

My Commission Expires the 1st day of January, 1902.

Witness my hand and the seal of said County, at Lincoln, Wisconsin, this 1st day of January, 1901.

Notary Public for the County of Lincoln, State of Wisconsin.

My Commission Expires the 1st day of January, 1902.

Witness my hand and the seal of said County, at Lincoln, Wisconsin, this 1st day of January, 1901.

Notary Public for the County of Lincoln, State of Wisconsin.

My Commission Expires the 1st day of January, 1902.

Witness my hand and the seal of said County, at Lincoln, Wisconsin, this 1st day of January, 1901.

Notary Public for the County of Lincoln, State of Wisconsin.

My Commission Expires the 1st day of January, 1902.

Witness my hand and the seal of said County, at Lincoln, Wisconsin, this 1st day of January, 1901.

Notary Public for the County of Lincoln, State of Wisconsin.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01335 CERTIFICATE OF DEATH 01318											
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY IN lb. <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence Before Admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PARSONS BURG</u> d. STREET ADDRESS <u>Route #50 (In Village)</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>LOUISE ELIZABETH PARSONS</u>			4. DATE OF DEATH Month <u>JANUARY</u> Day <u>7</u> Year <u>1962</u>			5. SEX <u>FEMALE</u>			6. COLOR OR RACE <u>WHITE</u>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH Month <u>August</u> Day <u>2</u> Year <u>1901</u>			9. AGE (In years last birthday) <u>60</u> yrs.			10. IF UNDER 1 YEAR: Months <u>6</u> Days <u>4</u> Hours <u>1/2</u> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary-Real Estate Office</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>Parsonsburg, Maryland</u>			11. BIRTHPLACE (County & State, or foreign country) <u>U S A</u>		
13. FATHER'S NAME <u>Laird W. Parsons (Deceased)</u>						14. MOTHER'S MAIDEN NAME <u>Carrie Bailey</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>						16. SOCIAL SECURITY NO. <u>Mrs. Carrie Parsons (Mother) Parsonsburg, Maryland</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 525 X IMMEDIATE CAUSE (a) <u>Pneumonia - due to Proctus</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <u>Acute Interstitial Fibrosis</u> (c) <u>(Hamman - Rich Disease)</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>4 1/2 yrs</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>N/A</u> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>N/A</u> 19 <u>62</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (the hospital) attended the deceased from <u>Jan 7 1962</u> to <u>Jan 7 1962</u> , that (I) (the) last saw the deceased alive on <u>Jan 7 1962</u> , and that death occurred at <u>11:30 PM</u> , from the causes and on the date stated above. 22a. SIGNATURE <u>Thomas C. Hill Jr.</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <u>Dr. Thomas C. Hill Jr.</u> 22d. ADDRESS <u>Pine Bluff Road Salisbury, Maryland</u> 22b. DATE SIGNED <u>1/7/62</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Jan. 10, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parsonsburg Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Parsonsburg, Maryland</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY SALISBURY, MARYLAND</u>						25a. REC'D BY REGISTRAR <u>JAN 9 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kenna</u>			

(M)

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W. C. M. C. O.

STANBURY

THE NEW YORK GENERAL HOSPITAL

HOUSE ELIZABETH PARK

NEW YORK CITY

NEW YORK, N. Y.

NEW YORK, N. Y.

NEW YORK, N. Y.

NEW YORK, N. Y.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
01336					01319				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)				
a. COUNTY		Wicomico			a. STATE		Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Willards			b. COUNTY		Wicomico		
c. LENGTH OF STAY IN 1b		25Yrs			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		X Willards		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
XX					RFD				
3. NAME OF DECEASED					4. DATE OF DEATH				
(Type or print)		ROBERTA FRANCES PETERSON			Month		Day		Year
					Jan. 5, 1962		19		
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Sept. 29, 1919		42 yrs.	Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Housewife			Own Home		Maryland		USA		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
Robert Houston					Una Ward				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
XX		XX		Stura Peterson Willards, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic myocarditis</i>									
42 DUE TO									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO									
DUE TO									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)									
<i>Severe upper respiratory infection (viral)</i>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY		Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
Hour a.m. p.m.		19		While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
21. I certify that (I) (this hospital) attended the deceased from <i>1-5-55</i> , 19 <i>55</i> , to <i>1-5-62</i> , 19 <i>62</i> , that (I) (we) last saw the deceased alive on <i>1-5-62</i> , 19 <i>62</i> , and that death occurred at <i>10 A.M.</i> , from the causes and on the date stated above.									
22a. SIGNATURE					ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED
<i>Frank Lewis</i>					M.D.				
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS				
					<i>Willards Maryland</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
Burial		1/8/62		New Hope		Willards, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
<i>Peter Whaley - Selbyville, Del.</i>					DATE JAN 9 '62		<i>Arthur L. Kline</i>		



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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-2. Page 5 may be retained by your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
FM 7159

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01337 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01320											
Item 9 Film G302 1/11/62 iwk											
1. PLACE OF DEATH a. COUNTY Wicomico				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 4 yrs			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital				e. STATE Maryland				f. COUNTY Wicomico			
5. SEX M				6. COLOR OR RACE C				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH APR. 10 1925				9. AGE (In years last birthday) 36 3/4 yrs.				10. IF UNDER 1 YEAR 1-3-62 Months Days			
11. IF UNDER 24 HRS. 19 Hours Min.				12. CITIZEN OF WHAT COUNTRY U.S.A				13. FATHER'S NAME John Postley			
14. MOTHER'S MAIDEN NAME Laura Jester				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) None				16. SOCIAL SECURITY NO. 21614-2751			
17. INFORMANT Laura Postley				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema DUE TO 42.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Aortic stenosis. DUE TO (c) 				INTERVAL BETWEEN ONSET AND DEATH Hours Years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
22. ACTUAL SIGNATURE Earl L. Royer				22a. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22c. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22d. DATE SIGNED 1-3-62				22e. EXAMINER'S NAME (Type) Earl L. Royer, M.D.			
22f. ADDRESS (Street, city, town, or county) 407 Camden Ave. Salisbury, Md.				22g. LOCATION (City, town, or county) (State) Salisbury Md.				22h. REC'D BY REGISTRAR JAN 8 '62			
22i. REGISTRAR'S SIGNATURE Booker McWest				22j. BURIAL, CREMATION, REMOVAL (Specify) Burial				22k. DATE THEREOF 1-7-62			
22l. NAME OF CEMETERY OR CREMATORY Class Hill Cem				22m. LOCATION (City, town, or county) (State) Salisbury Md.				22n. REC'D BY REGISTRAR JAN 8 '62			
22o. REGISTRAR'S SIGNATURE Arthur S. House				22p. NAME OF CEMETERY OR CREMATORY Class Hill Cem				22q. LOCATION (City, town, or county) (State) Salisbury Md.			

01387

01387

UNITED STATES DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of deceased: *John Doe*
2. Sex: *Male*
3. Age: *45*
4. Date of death: *10-15-68*
5. Place of death: *Home*
6. Cause of death: *Heart Disease*
7. Manner of death: *Natural*
8. Signature of Medical Examiner: *[Signature]*
9. Date of examination: *10-15-68*
10. Location of examination: *Home*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02537

01338

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset ✓		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY in 1b 3,117 days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Marion Station	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Deer's Head State Hospital			d. STREET ADDRESS RFD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) Page E. Pusey			4. DATE OF DEATH Month January Day 31 Year 19 62		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 1872		9. AGE (In years last birthday) 89 yrs. IF UNDER 1 YEAR: Months 19 Days 12 IF UNDER 24 HRS.: Hours 12 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sawyer		10b. KIND OF BUSINESS OR INDUSTRY Lumber		11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME Levin Fusey			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-16-1609		17. INFORMANT Mrs. Lola Gaylor, Washington, D. C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema DUE TO (b) Arteriosclerotic cardiovascular disease DUE TO (c) Arteriosclerosis, general					INTERVAL BETWEEN ONSET AND DEATH 12 hours Years Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 20, 1953, to Jan. 31, 1962 that (I) (we) last saw the deceased alive on Jan. 31, 1962 , and that death occurred at 10:37 P.M. from the causes and on the date stated above.					
22a. SIGNATURE V. Guerman		M.D. V. Guerman, M. D.		22b. DATE SIGNED 2/1/62	
22c. PHYSICIAN'S NAME (Type) V. Guerman, M. D.		22d. ADDRESS Deer's Head Hospital; Salisbury, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/3/62		23c. NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery	
23d. LOCATION (City, town or county) Marion Station, Md.		(State)			
24 FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons, Crisfield, Md.			ADDRESS		25a. REC'D BY REGISTRAR DATE FEB 7 '62
25b. REGISTRAR'S SIGNATURE Arthur L. Thomas					

VR A15 (4)
15M 9/60

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01339

CERTIFICATE OF DEATH

01321

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN b. <u>4 mo</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> d. STREET ADDRESS <u>204 Hayward Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Beatrice Ethel Penshaw</u>		4. DATE OF DEATH Month <u>January</u> Day <u>1</u> Year <u>1962</u>		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>July 23 1907</u>		9. AGE (In years last birthday) <u>54</u> yrs. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. PLACE OF BIRTH (Country & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Ellwood</u>	
14. MOTHER'S MAIDEN NAME <u>May Townsend</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes give year or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u> </u> Address <u> </u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> DUE TO (b) <u>Congestive heart failure</u> DUE TO (c) <u>Diabetes mellitus</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. <u> </u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>		20c. TIME OF INJURY Hour <u> </u> e.m. <u> </u> p.m. <u> </u> Month, Day, Year <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>		21. I certify that (I) (this hospital) attended the deceased from <u>July 1, 1961</u> , to <u>Jan 1, 1962</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>Jan 1, 1962</u> , and that death occurred at <u>12:00 PM</u> from the causes and on the date stated above.		22a. SIGNATURE <u>George H. Henning</u> M.D. 22b. DATE SIGNED <u> </u>		22c. PHYSICIAN'S NAME (Type) <u> </u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-4-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Grace Cemetery</u>		23d. LOCATION (City, town or county) <u>Mt Vernon, MD</u> (State) <u> </u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Lewis R. Wilson</u> ADDRESS <u>Pr. Ann, Md</u>	
25a. REC'D BY REGISTRAR <u> </u> 25b. REGISTRAR'S SIGNATURE <u> </u>		25c. DATE <u>JAN 8 '62</u>		25d. REGISTRAR'S SIGNATURE <u> </u>		25e. DATE <u> </u>		25f. REGISTRAR'S SIGNATURE <u> </u>	

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Miss
Mrs. J. H. H. H.

July 23 1907
Mrs. J. H. H. H.

Received of Mrs. J. H. H. H.
the sum of \$10.00

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
01340					01322				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)				
a. COUNTY Wicomico					a. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury					b. COUNTY Wicomico				
c. LENGTH OF STAY IN 1b 2Yrs.9Mos.10Days					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital					d. STREET ADDRESS R.D.# 5 (Quantico Rd)				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH						
First Middle Last Emma Frances Richardson			Month Day Year January 26 19 1962						
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 10, 1877		9. AGE (In years last birthday) 84 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work at Home		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Wicomico County, Md.		12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME Henry Clay Mills					14. MOTHER'S MAIDEN NAME Mary Ellen Phillips				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No					16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. Roxie Wells (Daughter) R.D.#5 Sal. Md. Hospital Records -- Salisbury, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia - Chronic DUE TO 332x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arteriosclerosis, General DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Recurrent Cerebral Thrombosis due to arteriosclerosis									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19									
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from 1/21/59 , 19....., to 1/26/62 , 19....., that (I) (we) last saw the deceased alive on 1/26/62 , 19....., and that death occurred at 5P M, from the causes and on the date stated above.									
22a. SIGNATURE V. Juerman M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED Jan. 26/1962									
22c. PHYSICIAN'S NAME (Type) V. Juerman, M.D. 22d. ADDRESS Deer's Head State Hosp. - Salisbury, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial									
23b. DATE THEREOF Jan. 29, 1962									
23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery									
23d. LOCATION (City, town or county) (State) Salisbury, Maryland									
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS HOLLOWAY & COMPANY SALISBURY, MARYLAND									
25a. REC'D BY REGISTRAR JAN 30 '62 25b. REGISTRAR'S SIGNATURE Arthur L. Hanes									

VR A15 (4)
15M 9/60

01360

(M)

HOLLOWAY & COMPANY, SALLISBURY, MARYLAND

Serial Jan. 22, 1952

V. Westcott, re:.

Jan. 16, 1952

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please call the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

<div>Items 18-21 Film 305</div> <div>1-22-62 ams</div> <div>305</div> <div>MD</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>01341 MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>01323</div>											
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury (Rural)					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) R.D.# 1						d. STREET ADDRESS R.D.# 1					
3. NAME OF DECEASED (Type or print) ERNEST H. RIGGIN						4. DATE OF DEATH Month JANUARY Day 8 Year 1962					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 25, 1889		9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months 1 Days 13	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer						10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Worcester Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Sidney Riggin						14. MOTHER'S MAIDEN NAME Martha Timmonds					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No						16. SOCIAL SECURITY NO. Informant					
17. INFORMANT Mrs. Katherine A. Howard (Daughter) R.D.#2 Snow Hill, Maryland						Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Exposure to cold 932.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Second degree burns of 15% body surface										INTERVAL BETWEEN ONSET AND DEATH Hours	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Found dead in unheated shack. Apparently had scalded himself with hot liquid					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 1 p.m. 6		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Wicomico Md.		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Dr. Earl L. Royer						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) 407 Camden Ave. Salisbury, Md.						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial						22b. DATE THEREOF Jan. 11, 1962		22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or country) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR HOLLOWAY & COMPANY SALISBURY, MARYLAND						24a. REC'D BY REGISTRAR JAN 17 '62		24b. REGISTRAR'S SIGNATURE Arthur L. Howard		DATE SIGNED Jan. 10 / 1962	

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MASSACHUSETTS DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS AND STATISTICS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
01343
CERTIFICATE OF DEATH
01325

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen Gen Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last ALICE MEADE ROSS				4. DATE OF DEATH Month Day Year JANUARY 16th 19 62			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 4, 1877		9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months 4 Days 12 Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work at Home		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Stephen R. Howell				14. MOTHER'S MAIDEN NAME Margaret V. Patrey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mr. Howard G. Ross (Husband) 734 Rogers St Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Insufficiency DUE TO 153.8 Circumstances, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Intestinal Obstruction DUE TO Carcinoma Colon (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						INTERVAL BETWEEN ONSET AND DEATH 2 days 5 days 1 yr.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/3, 1962 to 1/16, 1962 that (I) (we) last saw the deceased alive on 1/16, 1962 and that death occurred at 3:52 A.M. from the causes and on the date stated above.							
22a. SIGNATURE W. B. Smith M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Jan. 19 / 1962	
22c. PHYSICIAN'S NAME (Type) Dr. William B. Smith				22d. ADDRESS Salisbury, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 19, 1962		23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		23d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS HOLLOWAY & COMPANY SALISBURY, MARYLAND				25a. REC'D BY REGISTRAR DATE JAN 19 '62		25b. REGISTRAR'S SIGNATURE Charles S. Kraus	

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CERTIFICATE OF DEATH

AMERICAN ASSOCIATION OF DEATH RECORDERS

1934

Form with multiple lines for text entry, including fields for name, date, and cause of death. The text is mostly illegible due to fading and bleed-through from the reverse side.

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 01344
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH
 01326

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parsonsbury				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION In Village				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOHN Middle BENJAMIN Last SHOCKLEY				4. DATE OF DEATH Month JANUARY Day 16 Year 19 62			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 4, 1884	
9. AGE (In years lost birthday) 77 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer & Carpenter		11. BIRTHPLACE (State or foreign country) Wicomico Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Emory Shockley				14. MOTHER'S MAIDEN NAME Lavenia Figgs			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Amanda M. Shockley (Wife) Parsonsbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Coronary thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio-sclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1962 to 1-16 19 62 , that (I) (we) last saw the deceased alive on 1-15-1962 , and that death occurred at M , from the causes and on the date stated above.							
22a. SIGNATURE Philip A. Insley				22b. DATE SIGNED Jan. 17 / 1962			
22c. PHYSICIAN'S NAME (Type) Dr. Philip A. Insley				22d. ADDRESS Main St. Salisbury, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 19, 1962		23c. NAME OF CEMETERY OR CREMATORY Line Church Cemetery - R.D. # Pittsville, Md.		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANT				ADDRESS SALISBURY, MARYLAND		25a. REC'D BY REGISTRAR JAN 22 1962	
				25b. REGISTRAR'S SIGNATURE C. H. H. H. H.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MAYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01345

01327

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Caroline	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury, Maryland		c. LENGTH OF STAY IN 1b 1yr 6mo 28days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ridgely	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Deer's Head State Hospital		d. STREET ADDRESS None		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Ella Elizabeth Smith		4. DATE OF DEATH Month Day Year Jan 6 19 62			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH March 24, 1883		9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charles H. White		14. MOTHER'S MAIDEN NAME Anna Ritter Mattee	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. 220-01-4113		17. INFORMANT Edward Smith	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of breast with general metastases DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Salisbury		20g. (County) Wicomico		20h. (State) Maryland	
21. I certify that (I) (this hospital) attended the deceased from June 9, 1960, to Jan 6, 1962, that (I) (we) last saw the deceased alive on Jan 6, 1962, and that death occurred at 3 P.M. from the causes and on the date stated above.					
22a. SIGNATURE W. Maldve		22b. DATE SIGNED Jan. 7, 1962		22c. PHYSICIAN'S NAME (Type) L. Maldve, M.D.	
22d. ADDRESS Salisbury, Maryland		22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22f. DATE SIGNED Jan. 7, 1962	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-10-62		23c. NAME OF CEMETERY OR CREMATORY Cokers	
23d. LOCATION (City, town or county) Greensboro, Maryland		23e. (State) Maryland		23f. (Country) U.S.A.	
24. FUNERAL DIRECTOR'S SIGNATURE John E. Boula's Jr.		24a. ADDRESS Greensboro Md		24b. REC'D BY REGISTRAR JAN 9 '62	
24c. REGISTRAR'S SIGNATURE Arthur L. Krause		24d. DATE JAN 9 '62		24e. (City, town or county) Salisbury, Maryland	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please call the Director. Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01346 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01328											
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>						c. LENGTH OF STAY IN 1b <u>12</u> <u>Salisbury</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Pen Gen Hospital</u>						d. STREET ADDRESS <u>904 West Main St</u>					
3. NAME OF DECEASED (Type or print) First <u>ERVIN</u> Middle <u>LEE</u> Last <u>SMITH</u>						4. DATE OF DEATH Month <u>JANUARY</u> Day <u>13th</u> Year <u>19 62</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 23, 1911</u>		9. AGE (In years last birthday) <u>50</u> yrs.		IF UNDER 1 YEAR Months <u>9</u> Days <u>20</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Refrigeration & Elect. Repairman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sussex Co. Delaware</u>		11. BIRTHPLACE (State or foreign country) <u>U S A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>					
13. FATHER'S NAME <u>Lorenzo W. Smith</u>						14. MOTHER'S MAIDEN NAME <u>Mollie E. Records</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>						16. SOCIAL SECURITY NO. <u>Mrs. Ethel Byrd Smith (Wife)</u>					
17. INFORMATION <u>904 West Main St. Salisbury, Maryland</u>											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>428.1</u> <u>Crowning Occlusion</u> DUE TO (b) <u>Interval between onset and death</u> DUE TO (c) <u>Under</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.			2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Jan. 16 /1962</u>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Jan. 17 /1962</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park-Salisbury, Maryland</u>				22d. LOCATION (City, town, or country) (State) <u>Salisbury, Maryland</u>	
23. FUNERAL DIRECTOR <u>HOLLOWAY & COMPANY</u>						24a. REC'D BY REGISTRAR <u>DATE JAN 19 '62</u>					
24b. REGISTRAR'S SIGNATURE <u>William L. Thomas</u>											

ACTUAL SIGNATURE Dr. Earl L. Royer
EXAMINER'S NAME (Type) 407 Camden Ave. Salisbury, Maryland

DATE SIGNED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
01348									
01330									
1. PLACE OF DEATH a. COUNTY Wicomico					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury					c. LENGTH OF STAY IN 1b 9 Mos. 15 Days				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Deer's Head State Hospital					e. STREET ADDRESS Schumaker Rd.				
3. NAME OF DECEASED (Type or print) Amelia Catherine Townsend					4. DATE OF DEATH January 13 19 62				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Apr. 5, 1880		9. AGE (In years last birthday) 81 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13. FATHER'S NAME Samuel Shockley					14. MOTHER'S MAIDEN NAME Henrietta Webster				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO					16. SOCIAL SECURITY NO. None		17. INFORMANT Hospital Records -- Salisbury, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cor Pulmonale DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Emphysema Pulmonary DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Tracheobronchitis --- Chronic 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from 3/29/61, 19 to 1/13/62, 19, that (I) (we) last saw the deceased alive on 1/13/62, 19, and that death occurred at 6:15 A.M. from the causes and on the date stated above. 22a. SIGNATURE V. Juerman 22c. PHYSICIAN'S NAME (Type) V. Juerman, M.D. 22b. DATE SIGNED 1/13/62 22d. ADDRESS Deer's Head State Hospital - Salisbury 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 1-16-1962 23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park 23d. LOCATION (City, town or county) (State) Salisbury, Md. 24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Hill & Johnson Funeral Home, Salisbury, Md. 25a. REC'D BY REGISTRAR DATE JAN 16 '62 25b. REGISTRAR'S SIGNATURE Arthur L. Kraus									

VR A15 (4)
15M 9/60

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01342

Will a Johnson funeral home, Salisbury, Md.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01349

01331

1. PLACE OF DEATH a. COUNTY Wicomico County MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b 977 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Deer's Head State Hospital				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE Maryland b. COUNTY Somerset County c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield d. STREET ADDRESS Mariners Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) John Alfred TURPIN		4. DATE OF DEATH Month January Day 5 Year 1962					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 8, 1878	9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (County & State, or foreign country) Maryland (Kingston)		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Alfred Turpin			14. MOTHER'S MAIDEN NAME Elizabeth Bell				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give year or dates of service)		16. SOCIAL SECURITY NO. 220-01-7994		17. INFORMANT Mrs. Alvin Stant--Mariners Rd.--Crisfield, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Failure 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) Generalized Arteriosclerosis (e), stating the underlying cause last. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 2 da 5 yrs		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from May 4, 1959 , to Jan. 5, 1962 , that (I) (we) last saw the deceased alive on Jan. 5, 1962 , and that death occurred at 9:05 A.M. , from the causes and on the date stated above.							
22a. SIGNATURE Lee L. Lawry		22b. DATE SIGNED 1/5/62	22c. PHYSICIAN'S NAME (Type) Lee L. Lawry, M.D.				
22d. ADDRESS Deer's Head State Hospital Salisbury, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 7, 1962		23c. NAME OF CEMETERY OR CREMATORY Sunnyridge Cemetery			
23d. LOCATION (City, town or county) Crisfield, Md.		(State)					
24. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons--Crisfield, Md.			25a. REC'D BY REGISTRAR JAN 8 '62				
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60



01342

Shelton County

Shelton

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Shelton Head State Hospital

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Shelton Head State Hospital

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01350

01332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>20 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Deer's Head State Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u> ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> d. STREET ADDRESS <u>44 Graham Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <u>Nora</u> Middle <u>Nichols</u> Last <u>Turpin</u>				4. DATE OF DEATH Month <u>January</u> Day <u>22</u> Year <u>19 62</u>											
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-31-1888</u>									
9. AGE (In years last birthday) <u>73</u> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FACTORY</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>	
IF UNDER 1 YEAR		IF UNDER 24 HRS.													
Months	Days	Hours	Min.												
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>William Turpin</u>		14. MOTHER'S MAIDEN NAME <u>MARY S. WILSON</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give year or dates of service)									
16. SOCIAL SECURITY NO. <u>220-16-7685</u>		17. INFORMANT <u>Philip Turpin - Easton, Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ca. of the left lower jaw, with metastases</u> DUE TO (b) <u>1961</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 year ?</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchopneumonia</u>															
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from Jan. 2, 1962, to Jan. 22, 1962., that (I) (we) last saw the deceased alive on Jan. 22, 1962., and that death occurred at M. from the causes and on the date stated above.															
22a. SIGNATURE <u>V. Juerman</u> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>1/23/62</u>									
22c. PHYSICIAN'S NAME (Type) <u>V. Juerman, M. D.</u>				22d. ADDRESS <u>Deer's Head Hospital; Salisbury, Md.</u>											
23a. BURIAL, CREMATION, or other disposal (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>Jan. 27 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Richards Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Easton, Md.</u>									
24. FUNERAL DIRECTOR'S SIGNATURE <u>James S. Doherty</u>				24a. ADDRESS <u>Easton, Md.</u>		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <u>JAN 30 '62</u>									

MEDICAL CERTIFICATION

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MASTERS OF THE VESSEL OF THE
SOUTH-EAST COAST
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William Turner
Lumber Factory
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MAKING WILSON
William Turner - Enston W.

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James B. Jones
James B. Jones

Enston

Ms.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01351

CERTIFICATE OF DEATH

01333

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General</u>			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eden</u> d. STREET ADDRESS <u>R.D.# 2</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>CLARA</u> First Middle Last 5. SEX <u>Female</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>April 22, 1887</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>74</u> yrs. 10. UNDER 1 YEAR <u>8</u> Months 11. UNDER 24 HRS. <u>21</u> Hours <u>Min.</u>			4. DATE OF DEATH <u>January 13, 1962</u> Month Day Year 12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Canada</u> 12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>			13. FATHER'S NAME <u>Robert Wellwood</u> 14. MOTHER'S MAIDEN NAME <u>Jeanette Ames</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. (If any give war or dates of service) 17. INFORMANT <u>Mrs Jean Preston (Sister)</u> Address <u>Eden, Maryland</u>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO (b) <u>Metastases from Cancer of Jaw</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>12/29/61</u> , 19 <u>61</u> , to <u>1/13/62</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>12/29/61</u> , 19 <u>61</u> , and that death occurred at <u>5:12 PM</u> , from the causes and on the date stated above.					
22a. SIGNATURE <u>Carrie Hearn</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>CARRIE HEARN</u>			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>N. Division St Salisbury, Md.</u> 22b. DATE SIGNED <u>1-13-62</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan. 18 / 62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Wico. Memorial Park</u>	
23d. LOCATION (City, town or county) (State) <u>Salisbury, Maryland</u>		24 FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u> ADDRESS <u>SALISBURY, MARYLAND</u>			
25a. REC'D BY REGISTRAR <u>JAN 17 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hearn</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

01821

(M)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01352

CERTIFICATE OF DEATH

01354

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Delmar</u> c. LENGTH OF STAY IN 1b <u>7 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>108 Chestnut Street</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Delmar</u> d. STREET ADDRESS <u>108 Chestnut Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ROYAL GILLETTE WESSELLS</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>10th</u> Year <u>19 62</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 9, 1880</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. AGE (In years last birthday) <u>81</u> yrs.	11. BIRTHPLACE (County & State, or foreign country) <u>USA</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Isaac Wessells</u>	
14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Jewel Baker, Delmar, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>20-X</u> DUE TO <u>Multiple myeloma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>virus enteritis, acute</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>e.m.</u> 19 <u>62</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 1st 1961</u> to <u>Jan 10th 1962</u> that (I) (we) last saw the deceased alive on <u>Jan 10th 1962</u> and that death occurred at <u>5:45 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>L.V. Sohler</u>		22b. DATE SIGNED <u>Jan 11th 62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. L.V. Sohler</u>		22d. ADDRESS <u>Delmar, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-13-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Parksley Baptist</u>		23d. LOCATION (City, town or county) <u>Parksley, Va.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W.S. Marvel Co - Delmar, Md.</u>		25a. REC'D BY REGISTRAR <u>Arthur L. Hume</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>JAN 15 '62</u>	

2660



W. L. Brown & Co. - Boston, Mass.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01353

01335

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY IN 1b <u>4 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA GENERAL Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Fruitland</u> d. STREET ADDRESS <u>Route #1 Box 353</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>ANNA LOU NEST</u>			4. DATE OF DEATH <u>JANUARY 30 1962</u>				
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>NEGRO</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>7-8-1937</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (County & State, or foreign country) <u>ALABAMA</u>			
13. FATHER'S NAME <u>JAMES KLEST</u>			14. MOTHER'S MAIDEN NAME <u>WINIFRED ROWE</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>JAMES WEST, Fruitland, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>456 X</u> IMMEDIATE CAUSE <u>Disseminated Lupus Erythematosus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) DUE TO					INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____			
20f. (City or town) _____		(County) _____		(State) _____			
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at <u>12:30 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>David Gilmore</u>			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED _____		
22c. PHYSICIAN'S NAME (Type) <u>David Gilmore, M.D.</u>			22d. ADDRESS <u>Salisbury, Md</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-4-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ant. Calvary Cem</u>			
23d. LOCATION (City, town or county) <u>Fruitland, Md.</u>		(State) _____					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Thornton B. Jolley</u>			ADDRESS <u>Salisbury, Md</u>		25a. REC'D BY REGISTRAR <u>FEB 6 '62</u>		
25b. REGISTRAR'S SIGNATURE <u>Carroll S. Hines</u>			_____				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/6D

(M)

(1)

6323

DATE OF BIRTH

4-1-1901

Wife

James West

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James West

James West

James West

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01354

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01336

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please extend the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>12</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>609 Smith St.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> d. STREET ADDRESS <u>609 Smith St.</u>									
3. NAME OF DECEASED (Type or print) <u>George Clinton White</u>		4. DATE OF DEATH Month <u>1-14</u> Day <u>62</u> Year <u>1962</u>		5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 3, 1939</u>		9. AGE (In years last birthday) <u>22</u> yrs. IF UNDER 1 YEAR: Months <u>10</u> Days <u>11</u> IF UNDER 24 HRS.: Hours <u>11</u> Min. <u>11</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Employee-Shirt Factory</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Salisbury, Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>					
13. FATHER'S NAME <u>Benjamin Franklin White</u>				14. MOTHER'S MAIDEN NAME <u>Sussie Joyner Keeter</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes give war or dates of service)					
16. SOCIAL SECURITY NO. <u>R.D.#5 High Banks - Salisbury, Maryland</u>				17. INFORMANT Address <u>Mr. Richard L. Moore (Brother-In-Law)</u> <u>R.D.#5 High Banks - Salisbury, Maryland</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bullet wound of chest</u> DUE TO (b) <u>976X</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u>Acute depression</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot self in chest with 22 calibre rifle.</u>									
20c. TIME OF INJURY Month, Day, Year <u>1-14-62</u> Hour <u>11</u> a.m. <u>11</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Own home.</u>		20f. (City or town) <u>Salisbury</u>		(County) <u>Wicomico</u>		(State) <u>Md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <u>Earl L. Royer, M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>1-17-62</u>					
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Jan. 17, 1962</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Siloam Cemetery</u>		22d. LOCATION (City, town, or country) <u>Siloam, Maryland</u>		(State)			
23. FUNERAL DIRECTOR <u>HOLLOWAY & COMPANY</u>				ADDRESS <u>SALISBURY MARYLAND</u>				24a. REC'D BY REGISTRAR <u>JAN 19 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Conning S. House</u>			

10-10-1918

Wisconsin

Salisbury

500 Smith St.

George

Clinton

Wisconsin

Salisbury

500 Smith St.

George

Clinton

Employee - First Party

Residence - 100 Main St.

Residence - 100 Main St.

Residence - 100 Main St.

Case No. 100-100-100

1-10-1918

Handwritten signature

Harry E. Hoover

507 Main St.

Salisbury, Wis.

507 Main St.

Salisbury, Wis.

1-17-18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, as 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01355

01337

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN lb <u>since 12/29/61</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Pine Bluff State Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> d. STREET ADDRESS <u>309 Penn. Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>BETTIE LOUISE WILLEY</u> 5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>October 27, 1884</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>77</u> yrs.				10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Dorchester Co., Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Charles A. Johnson</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or date of service) 16. SOCIAL SECURITY NO. <u>219-07-7736</u>				14. MOTHER'S MAIDEN NAME <u>Louise Drucilla Tyler</u> 17. INFORMANT <u>Mr. Charles W. Willey (Son) Home address above.</u> 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (b) <u>422.1</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u>Emphysema</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Emphysema</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour e.m. <u>8:00 p.m.</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Pine Bluff Hospital, Salisbury, Md.</u> 20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <u>12/29/61</u> , 19 <u>62</u> , to <u>1/13</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>1/13</u> , 19 <u>62</u> , and that death occurred <u>8:00 p.m.</u> on the causes and on the date stated above. 22a. SIGNATURE <u>E.P. Ritchings</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> DATE <u>1/14/62</u> 22c. PHYSICIAN'S NAME (Type) <u>E.P. Ritchings</u> 22d. ADDRESS <u>Pine Bluff Hospital, Salisbury, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>Jan. 16, 1962</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Charity Church Cemetery- R.D.# Salisbury, Md.</u> 23d. LOCATION (City, town or county) (State)				24. FUNERAL DIRECTOR'S SIGNATURE <u>Holloway & Co</u> ADDRESS <u>Sal. Md.</u> 25a. REC'D BY REGISTRAR <u>JAN 17 '62</u> DATE 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Haines</u>			

01335

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February 4 1962
202. 740.